ADULT MENTAL HEALTH HABILITATION PROGRAM PROVIDER MANUAL

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ADULT MENTAL HEALTH HABILITATION (AMHH) PROGRAM PROVIDER MANUAL

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Provider Manual Revision History

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1.0	February 1, 2014	New Provider Manual	FSSA/DMHA

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SECTION 1: AMHH PROGRAM PROVIDER MANUAL INTRODUCTION

The Adult Mental Health Habilitation (AMHH) program provider manual is a resource specifically for the Indiana Family and Social Services Administration's Division of Mental Health and Addiction (FSSA/DMHA) approved AMHH service providers. Section 6086 of the Deficit Reduction Act of 2005 (DRA), Public Law Number 109-171, expanded access to Home and Community-Based Services (HCBS) for the Elderly and Disabled, by adding a new section 1915(i) to the Social Security Act ("the Act"). Under section 1915(i), States have the option to amend their State plans to provide HCBS without regard to state-wideness or certain other Medicaid requirements. AMHH services are approved by the Centers for Medicare and Medicaid Services (CMS) as 1915(i) HCBS services and may be provided for five (5) years following CMS approval of the State plan amendment (SPA) to provide AMHH services (CMS approval of initial AMHH SPA occurred on 09/25/2013),with an effective date of 10/01/2013 with an option to renew for an additional five (5) year period.

The AMHH program was adopted by Indiana to provide community-based opportunities for the care of adults with serious mental illness, with or without co-occurring substance use disorder(s), who may most benefit from a habilitation approach to care versus a rehabilitative approach.

HABILITATION VERSUS REHABILITATION

The distinction of whether a service is rehabilitative versus habilitative is often more rooted in an individual's level of functioning and needs than in the actual service provided. Federal law describes Medicaid rehabilitation services as any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a member to his best possible functional level. Habilitation services, by comparison, are defined as activities that are designed to assist individuals in acquiring, retaining, and improving the following skills necessary to reside successfully in a community setting:

- Self-help
- Socialization
- Adaptive skills

AMHH services are indicated as a service alternative for individuals who are no longer able to benefit from Medicaid Rehabilitation Option (MRO) services and whose needs can better be met through a habilitation approach. A possible candidate for AMHH services is an individual who has reached his/her capacity for improving their level of functioning, but needs to retain their current functional level in order to remain in the community. Habilitation services benefits the individual by providing them with the skills and supports needed to safely remain in a community-based setting and reduce their risk for institutionalization. Eligibility for AMHH services is determined based upon the individual meeting specific target and needs-based criteria outlined within this manual.

The AMHH provider manual documents the policies and procedures for the AMHH program, as well as the State and Federal expectations for AMHH service providers, and provides guidance regarding AMHH member eligibility determination, enrollment, service delivery, clinical documentation and billing. The manual is intended to be utilized in conjunction with the following resources:

- 1915(i) AMHH State Plan Amendment TN 12-003 approved by CMS.
- 1915(b)(4) AMHH Waiver approved by CMS.
- 405 IAC 5-21.6 (Indiana Administrative Code of AMHH services).

- Indiana Health Coverage Programs (IHCP) policies and expectations issued by FSSA.
- Any updates or policy revisions to the AMHH program or requirements for AMHH providers by the Indiana FSSA/DMHA.
- Bulletins issued by CMS or the FSSA.

Approved AMHH service providers are expected to review, understand and follow AMHH program policy and procedures, as well as any subsequent updates or revisions issued by CMS, FSSA/DMHA/OMPP. Failure to comply with state and federal regulations associated with this program and the expectations outlined in the provider manual will lead to formal corrective actions, state and federal sanctions or loss of approval as an AMHH service provider.

SECTION 2: ADULT MENTAL HEALTH HABILITATION (AMHH) SERVICES

Adult Mental Health Habilitation (AMHH) services refers to medical or remedial services recommended by a physician or psychologist endorsed as a health service provider in psychology (HSPP), within the scope of his or her practice, for the habilitation of a mental health disability and the restoration or maintenance of an individual's best possible functional level. AMHH services are clinical and supportive behavioral health services provided for individuals, families, or groups of adult persons who are living in the community and who need aid on a routine basis for a mental illness or co-occurring mental illness and addiction disorders. AMHH services are designed to assist in the habilitation of the individual's optimum functional ability in daily living activities. This is accomplished by:

- Assessing the individual's needs and strengths.
- Developing an Individualized Integrated Care Plan (IICP) that outlines objectives of care, including how AMHH services will assist in delivering appropriate home and community-based habilitation services to the individual.
- Assisting the individual in reaching their habilitative goals.

AMHH services are intended to benefit the following individuals:

- Adults who need aid on a routine basis for the management of serious mental illness (SMI) or co-occurring mental illness and addiction disorders and are living in a community-based setting.
- Adults that have reached the maximum benefit from a rehabilitative treatment approach and would be better served with access to a habilitation approach to services to help them maintain and enhance treatment gains that have already been made.
- Adults who have a high need for service utilization and are considered at risk of institutionalization without access to intensive community-based services.

Indiana has chosen to make available AMHH services for the following reasons:

- AMHH services will assist adults with SMI, with or without a co-occurring substance use disorder, in reaching or maintaining the highest level of independence and functioning possible through the reinforcement, management, adaptation and/or retention of skills necessary to live successfully in the community.
- Individuals with SMI who are limited in their ability for self-care and independence are empowered to remain integrated in their community with an appropriate level of supervision, services, and supports.
- Services will improve "quality of life" for individuals with SMI living in the community and decrease the need for institutional care.
- AMHH services fill a gap between Medicaid Rehabilitation Option (MRO) and Medicaid Clinic Option (MCO) services.

The following AMHH services are available, according to the coverage criteria, limitations and eligibility requirements specified within this manual, the AMHH SPA and 405 IAC 5-21.6:

- Adult day services
- Home and community-based habilitation and support
- Respite care
- Therapy and behavior support services
- Addiction counseling
- Peer support services
- Supported community engagement services

- Care coordination
- Medication training and support

Home and Community-Based Setting Requirements

As mandated in the CMS-approved 1915(i) AMHH SPA and 405 IAC 5-21.6, AMHH services will be furnished to individuals who reside in their home or in the community, not in an institution. CMS has issued a final rule regarding home and community-based settings (CMS 2249-F/2296-F), which establishes requirements for the qualities of settings that are eligible for reimbursement for 1915(i) services. Additional information can be found on the FSSA Home and Community-Based Services Final Rule website at: http://www.in.gov/fssa/4917.htm

Refer to *Section 6: AMHH Member Home and Community-Based Residence Requirements* for additional information.

Length Of Authorization Period

An eligible AMHH member is authorized to receive AMHH services on an approved Individualized Integrated Care Plan (IICP) for one year (360 days) from the start date of AMHH eligibility, or as determined by the FSSA/DMHA State Evaluation Team (SET). Services may be provided according to the FSSA/DMHA-approved IICP as long as the member continues to meet AMHH eligibility criteria. Once an applicant is determined eligible for AMHH services program, the SET will approve AMHH services based upon review of documentation and the IICP.

Covered AMHH Service Requirements

For a service to be reimbursable under the AMHH services program, it must meet the following minimum criteria:

- Be provided to an individual determined by the Division of Mental Health and Addiction's SET as eligible for AMHH services.
- Be a service proposed on the member's IICP and approved by the SET.
- Be a covered AMHH service, as described in this provider manual.
- Be provided in a manner that is within the scope and/or limitations of the AMHH service, including provider qualifications.
- Be supported in clinical documentation as a service that:
  - Continues to promote stability for the AMHH member; and
  - Enables the member to move toward obtaining the habilitative goals identified in the individual's IICP.

Non-Covered Services

While each AMHH service may have its own exclusions unique to that service, the following services are considered *non-covered* and are *not eligible for reimbursement* under the AMHH services program:

- A service provided to the member at the same time as another service that is the same in nature and scope, regardless of funding source, including Federal, State, local, and private entities (for example, clinic option, BPHC, and MRO)
- A service provided as a diversion, leisure or recreational activity unless it is an identified component of an approved respite care service.
- A service that is provided in a manner that is not within the scope and/or limitations of the AMHH service.

Note: Individuals enrolled in the AMHH program are not eligible for MRO services.

- A service either not on the member's IICP or service on the member's IICP that is not documented as a covered or approved service by the State Evaluation Team.
- A service provided that exceeds the limits within the service definition, including service quantity/limit, duration and/or frequency.
- Any service provided on the same day that the member is receiving inpatient or partial hospitalization through Medicaid.
- A service provided to the member at the same time as another service that is the same in nature and scope, regardless of funding source, including Federal, State, local, and private entities (e.g., BPHC, 1915(c) waiver. Any service provided simultaneously with another service, only one of the services provided is billable.)
- Time spent on the initial face to face assessment, referral form, and IICP may not be billed under AMHH.

CRISIS INTERVENTION SERVICES

As noted in 405 IAC 5-21.5-8, services reimbursable as crisis intervention services are short-term emergency behavioral health services, available twenty-four (24) hours per day, seven (7) days per week. These services include crisis assessment, planning, and counseling specific to the crisis, intervention at the site of the crisis when clinically appropriate, and pre-hospital assessment. The goal of crisis services is to resolve the crisis and transition the consumer to routine care through stabilization of the acute crisis and linkage to necessary services. This service may be provided in an emergency room, crisis clinic setting, or in the community.

Crisis intervention is a covered service for any Medicaid member; however, it is not a service that is defined in the AMHH SPA. If an AMHH member is in need of crisis intervention services, he/she may access these services.

SECTION 3: AMHH SERVICE PROVIDERS

AMHH services may only be delivered by service provider agencies meeting specific state-defined criteria. FSSA/DMHA certifies agencies to provide AMHH services to eligible members. DMHA approved providers must also be enrolled as an authorized IHCP provider with the AMHH specialty.

AMHH approved IHCP enrolled providers that meet specific provider standards and criteria developed to ensure that AMHH members receive access to a full continuum of behavioral health services that are provided in a manner that will ensure the health and safety of those individuals. In Indiana, community mental health centers (CMHCs) in good standing with FSSA/DMHA are eligible to be approved as IHCP enrolled AMHH service provider agencies.

PROVIDER AGENCY APPLICATION

To become an AMHH service provider agency, the CMHC must complete and return a *CMHC Provider Application and Attestation to Provide Adult Mental Health Habilitation Services* acknowledging the agency will adhere to the AMHH program policy and state requirements for all AMHH service providers, as described in this section. (Refer to *Appendix F: CMHC Provider Application and Attestation to Provide AMHH* for a sample form.) The completed provider application is returned to the FSSA/DMHA Director's office for review and approval or denial. FSSA/DMHA will document approval or denial of the CMHC's application to become an AMHH provider agency. If approved as an AMHH provider agency, FSSA/DMHA will notify IHCP to add AMHH to the existing CMHC provider profile. Approvals are valid for up to a 3-year period. Where possible, FSSA/DMHA will align the AMHH provider agency renewal process with the routine CMHC certification timeline. Ongoing, CMHCs that are approved to provide AMHH will need to assure they comply with rules and regulations noted on the IHCP website at www.indianamedicaid.com. If approved as an AMHH provider agency, the CMHC will have Specialty 115 – 1915(i) AMHH Service Provider added to their profile.

PROVIDER AGENCY REQUIREMENTS

All provider agencies must be approved by FSSA/DMHA and must meet the following AMHH provider agency criteria and standards:

- Be a FSSA/DMHA-certified Community Mental Health Center (CMHC) in good, including adherence to criteria required of all FSSA/DMHA-certified CMHCs.
- Has acquired and maintains a National Accreditation by an entity approved by FSSA/DMHA.
- Is an enrolled IHCP provider that offers a full continuum of care (See Chapter 4, Provider enrollment, eligibility and responsibilities for IHCP providers, found at http://provider.indianamedicaid.com/ihcp/manuals/chapter04.pdf).
- Must attest that they are willing and able to provide AMHH services as described in the AMHH SPA, 405 IAC 1-5-1 and 405 IAC 1-5-3 and the AMHH provider manual. This includes but is not limited to:
    - Must maintain documentation in accordance with IHCP requirements defined in 405 IAC 1-5-1 and 405 IAC 1-5-3 and outlined in the IHCP provider manual for all IHCP providers.
    - Meet all AMHH provider agency criteria, as defined in the AMHH SPA and 405 IAC 5-21.6 of the Indiana Administrative Code.
    - Employ individual providers that are eligible to provide AMHH services. Refer to *Agency Staff Requirements* subsection below for additional provider staff eligibility requirements.

PROVIDER AGENCY EXPECTATIONS

FSSA/DMHA approval of an agency as an IHCP enrolled AMHH provider agency is contingent upon that agency complying with all IHCP and AMHH program rules and policies. In addition to meeting AMHH provider agency requirements to be an IHCP enrolled provider for AMHH services, **all AMHH provider agencies will ensure that members are provided access to all the services and supports needed to meet his/her individualized needs.** AMHH provider agencies must adhere to the following:

- AMHH providers must provide information related to AMHH services, members and provider staff, as required/requested by FSSA/DMHA.
- Ensure that all direct care agency staff members providing AMHH services to a member meet all standards and qualifications required for the AMHH service being provided. CMHCs are responsible for maintaining accurate and up to date files for each staff member, including but not limited to proof of training.
- Actively participate in the FSSA/DMHA quality assurance program, ensuring compliance with all performance criteria set forth for the AMHH program. As required by the State, the agency shall participate in any quality improvement initiatives as they relate to the AMHH program.
- Participate in AMHH provider agency meetings, trainings, and/or conference calls and webinars provided or authorized by FSSA/DMHA
- Comply with FSSA/DMHA requirements regarding the reporting of critical incidents.
- Provide a system throughout its agency and network for handling individual complaints and appeals, including informing members of the availability of a toll-free number for the reporting of complaints to the State.
- Shall cooperate fully with the processing of any AMHH-related complaint or appeal, including any grievance plan or correction initiated by the State.
- Be compliant with all federal Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2 mandates and regulations in regards to consumer privacy and information sharing.
- Meet all clinical and operational standards and state requirements for a FSSA/DMHA-certified community mental health center, as found in 440 IAC 4.1.
- Maintain written policies and procedures for timely intake, screening and comprehensive evaluation to ensure members have access to appropriate mental health and addiction treatment services in a timely manner from the point a referral for AMHH services is received by the provider agency.
- **In the event a service or support required to meet the member's identified needs is not available or accessible by the member in a timely manner, the provider agency will provide or make provision for an alternative service or support to meet the member's identified needs, until such time the requested service becomes available.**
- Reapply for approval as an AMHH provider agency every 3 years, from the date of initial approval as an AMHH provider agency, as determined by FSSA/DMHA.

AGENCY STAFF REQUIREMENTS

An FSSA/DMHA-approved AMHH provider agency must ensure that the agency staff members providing the AMHH service meet the specific criteria and standards required for the AMHH service(s) they provide. The following categories of agency staff members may provide AMHH services, dependent upon meeting the other service-specific criteria required (Refer to *Sections 15 - 23* for service-specific provider standards and requirements):

LICENSED PROFESSIONAL

A licensed professional is defined by any of the following provider types:

- A licensed psychiatrist;
- A licensed physician;
- A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP);
- A licensed clinical social worker (LCSW);
- A licensed mental health counselor (LMHC);
- A licensed marriage and family therapist (LMFT); or
- A licensed clinical addiction counselor (LCAC), as defined under IC 25-23.6-10.5.

Qualified Behavioral Health Professional (QBHP)

A QBHP is defined by any of the following provider types:

- An individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as defined above, with such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:
    - In psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse in Indiana;
    - In pastoral counseling from an accredited university; or
    - In rehabilitation counseling from an accredited university.
- An individual who is under the supervision of a licensed professional, as defined above, is eligible for and working towards licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines:
    - In social work from a university accredited by the Council on Social Work Education;
    - In psychology from an accredited university;
    - In mental health counseling from an accredited university;
    - In marital and family therapy from an accredited university.
- A licensed independent practice school psychologist under the supervision of a licensed professional, as defined under the previous subsection.
- An authorized health care professional (AHCP) who is one (1) of the following:
    - A physician's assistant with the authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5.
    - A nurse practitioner or clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person's license, under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to IC 25-23-1.

Other Behavioral Health Professional (OBHP)

An OBHP is defined by any of the following provider types:

- An individual with an associate's or bachelor's degree, or equivalent behavioral health experience, meeting minimum competency standards set forth by a behavioral health service provider and supervised by either a licensed professional, as defined above in this section, or a QBHP, as defined above in this section.
- A licensed addiction counselor, as defined under IC 25-23.6-10.5, supervised by either a licensed professional as defined above in this section, or a QBHP, as defined above in this section.

AMHH Clinical Supervision Standards

Where clinical supervision for provider agency staff is required, it is expected that the provider has and implements clearly delineated policies and procedures for defining, implementing and documenting

clinical supervision as defined and required by AMHH service standards. Operational supervision is at the discretion of the AMHH provider agency to define and implement.

SECTION 4: AMHH MEMBER RIGHTS

AMHH provider agencies shall ensure that all AMHH members in their care retain the following rights:

- To receive appropriate behavioral health services in accordance with standards of professional practice, appropriate to the member's needs and designed to afford the individual a reasonable opportunity to maintain or improve his or her condition.
- To participate in the planning of the IICP, including receiving assistance in understanding and being informed of the nature of the treatment program proposed, the known effects of receiving and not receiving such treatment, and alternative treatments, if any.
- Right to refuse to submit to treatment, including medication or services as an adult voluntary patient.
- Being treated with consideration, dignity and respect, free from mental, verbal and physical abuse or neglect.
- Freedom of choice regarding which FSSA/DMHA-approved AMHH provider agency (or agencies) deliver AMHH services and the freedom to change AMHH provider agencies at any time during the AMHH services eligibility period.
- Confidentiality and protection of personal identifying and treatment-related information, as provided under HIPAA.

Each FSSA/DMHA-approved AMHH provider agency is required to ensure a written statement of rights is provided to each AMHH participant. The statement shall include:

- The toll-free consumer service line number and the telephone number for Indiana Protection and Advocacy.
- Documentation that the provider agency provided both a written and an oral explanation of rights to each applicant/member.

GRIEVANCE OR COMPLAINTS

The objective of the grievance or complaint reporting policy is to provide members with a formal process to ensure the individual can voice concerns, complaints, and grievances regarding the AMHH services program to FSSA/DMHA for review and resolution. Provider agencies are required to assist members in understanding their rights and options regarding filing a grievance or complaint about AMHH services and service delivery to FSSA/DMHA. Provider agencies are required to follow the FSSA/DMHA policy for grievances and complaints.

INCIDENT REPORTING

Incident reporting provides a mechanism for reporting and responding to critical or sentinel incidents occurring in connection with the AMHH services program. Provider agencies are required to follow the FSSA/DMHA requirements on critical incident reporting.

SECTION 5: AMHH PROGRAM MEMBER ELIGIBILITY

AMHH services are offered as a part of a Medicaid State Plan option for providing 1915(i) home and community-based services (HCBS) to promote and empower independence and integration into the community and as an alternative to an institutional level of care. This 1915(i) option allows Indiana to offer HCBS to individuals who are enrolled in Medicaid and meet specific target group and needs-based eligibility criteria. As defined in the AMHH SPA and in 405 IAC 5-21.6, Indiana elected to target the 1915(i) State Plan HCBS benefit to a specific population. Eligibility for the AMHH program is determined by the State Evaluation Team, and is based on the following criteria:

- Target Group Criteria
- Financial Criteria (enrolled in Medicaid)
- Needs-based criteria

ELIGIBILITY DETERMINATION & CONFLICT OF INTEREST

To ensure no conflict of interest in the final AMHH eligibility determinations, the responsibility for AMHH program eligibility determination and approval of the proposed AMHH services, in all cases, is retained by the FSSA/DMHA SET. Members of the SET are prohibited from having any financial relationships with the applicant or member requesting AMHH services, their families or the provider agency selected to provide AMHH services.

AMHH provider agencies are required to have written policies and procedures available for review by the State which clearly define and describe how conflict of interest requirements are implemented and monitored within the agency, protecting the individuals applying for AMHH services and the integrity of the AMHH program.

MEMBER ELIGIBILITY CRITERIA

The applicant must meet the following *target group* and *needs-based* criteria in order to be eligible to receive AMHH services:

TARGET GROUP CRITERIA

AMHH services are targeted for individuals who meet the all of following *target group* criteria:

- Individual is enrolled in eligible IHCP (Medicaid) program.
- Individual is age thirty-five (35) or older at time of initial application.
- Individual has an AMHH-eligible primary mental health diagnosis, which may include the following (Refer to *Appendix B* for a full listing of AMHH-eligible diagnosis codes):
    - Schizophrenic Disorders (295.xx)
    - Major Depressive Disorder (296.xx)
    - Bipolar Disorders (296.xx)
    - Delusional Disorder (297.1),
    - Psychotic Disorder NOS (298.9)
    - Obsessive-Compulsive Disorder (300.3)

NEEDS-BASED CRITERIA

In addition to meeting the AMHH target group criteria, the applicant must also meet all of the following needs-based criteria to be eligible for AMHH services:

- Without ongoing habilitation services as demonstrated by written attestation by a psychiatrist or Health Services Provider in Psychology (HSPP), the person is likely to deteriorate and be at risk of institutionalization (e.g., acute hospitalization, State hospital, nursing home, jail).
- Must demonstrate the need for significant assistance in major life domains related to their mental illness (e.g., physical problems, social functioning, basic living skills, self-care, and potential for harm to self or others). *Significant* means an assessed need for immediate or intensive action due to a serious or disabling need, and *assistance* means any kind of support from another person (e.g., mentoring, supervision, reminders, verbal cueing, or hands-on assistance) needed because of a mental health condition or disorder.
- Must demonstrate significant needs related to his/her behavioral health.
- Must demonstrate significant impairment in self-management of his/her mental illness or demonstrate significant needs for assistance with mental illness management.
- Must demonstrate a lack of sufficient natural supports to assist with mental illness management.
- The individual is not a danger to self or others at the time the application for AMHH services program eligibility is submitted for State review and determination.
- Individual has a recommendation for intensive community-based care on the Adult Needs and Strengths Assessment (ANSA) tool, with a level four (4) or higher. Refer to *Section 7: AMHH Member Application Process* for additional information about the assessment tool.

An applicant not meeting the target group and needs-based criteria as defined above will not be eligible to receive AMHH services under the 1915(i) HCBS state plan. When applicable, an ineligible applicant shall be linked to services that may meet their needs.

SECTION 6: AMHH MEMBER HOME AND COMMUNITY-BASED SETTINGS REQUIREMENTS

AMHH is a home and community-based service (HCBS) program. In accordance with federal regulations for 1915(i) State Plan HCBS programs, service activities are to be provided within the individual's home (place of residence) or at other locations based in the community. Service activities cannot not be provided in an institutional setting.

In January 2014, the Centers for Medicare and Medicaid Services (CMS) published regulations to better define the settings in which states can provide Medicaid Home and Community-Based Services (HCBS). The HCBS Final Rule became effective March 17, 2014. The HCBS Rule, along with additional guidance and fact sheets, is available on the CMS Home and Community Based Services site.

To view the HCBS State wide transition plan, go to The Home and The Home and Community Based Services Final Rule Based Services Final Rule link on FSSA.in.gov

Per CMS final rule on HCBS settings must exhibit the following qualities to be eligible sites for delivery of HCBS:

- Is integrated in and supports full access to the greater community
- Is selected by the individual from among setting options
- Ensures individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint
- Optimizes autonomy and independence in making life choices
- Facilitates choice regarding services and who provides them

There are additional requirements for provider-owned or -controlled home and community-based residential settings. These requirements include:

- The individual has a lease or other legally enforceable agreement providing similar protections
- The individual has privacy in his or her unit, including lockable doors, choice of roommates, and freedom to furnish or decorate the unit
- The individual controls his or her own schedule, including access to food at any time
- The individual can have visitors at any time
- The setting is physically accessible

The following are examples of settings that are not considered home or community-based:

1) Nursing facility
2) Institution for mental diseases
3) Intermediate care facilities for individuals with intellectually disabled
4) Hospitals
5) Any other location that has the qualities of an institutional setting. This may include, but is not limited to:

a) a setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or
b) in a building on the grounds of, or immediately adjacent to, a public institution, or
c) any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

AMHH Members and Choice of Living Arrangement

Many persons choosing to participate in AMHH services live in their own home, or with families or friends, in the same manner as any adult who does not have a mental illness. Among persons that may be eligible for AMHH services, though, are some who do not have family or friends with whom they can live, or are not functioning at a level where their health and safety can be supported in a totally independent setting. Depending upon a person's level of need and functioning, he/she may choose to live in full-time supervised settings, settings that provide less than full-time supervision or settings that provide no on-site supervision.

Prior to an individual's selection of a residential placement, alternatives are discussed with the individual, family, and guardian, as applicable. The decision for the choice of placement is based on the individual's identified needs, goals and resources. Once the resident's placement is selected by him/her, an IICP is developed and/or updated with the resident. The IICP reflects his/her aspirations and goals towards an independent lifestyle and how the residential setting contributes to empowering the individual to continue to live successfully in the community.

FSSA/DMHA supports a permanent supportive housing model which refers to a housing unit that is linked with community-based services. The tenant holds the lease with a landlord and receives services based on need through a community mental health center or community service agency. The tenant's housing is not contingent on the person participating in any mental health or addiction services. The individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the state's landlord tenant law of the state, county, city or other designated entity. Each individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected.

FSSA/DMHA Certified Residential Facility Settings – Standards, Rights, and Definitions

The FSSA/DMHA certified residential settings in which some individuals may choose to live will promote opportunities that assist and support each individual to grow and develop skills needed to continue to live in the community. FSSA/DMHA certified residential care settings are a component of an outpatient community-based continuum of care, designed to provide an array of living options that span the continuum from minimal oversight to highly supervised settings. These settings are not a Nursing Facility, Intermediate Care Facility for Individuals with Intellectual Disability or an Institute for Mental Diseases. The residential care settings do not have any qualities of an institution, nor would they be permitted to be located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or disability-specific housing complex. One of the primary goals of the AMHH service program is to provide services and support to individuals to ensure they live safely and as independently as possible in the community. The program intends to provide opportunities for individuals to get their needs met in community-based settings and to prevent need for and placement in institutional settings.

FSSA's DMHA and OMPP have a strong partnership with state housing agencies: Indiana Housing and Community Development and Corporation for Supportive Housing. Together, these agencies have

facilitated the development of supportive housing integrated into the community to meet the needs of individuals with mental health and addiction disorders. FSSA/DMHA, through certification and licensure standards, requires the individual's participation in planning their care and supports the recovery philosophy that promotes the least restrictive, most appropriate care to safely meet the individual's identified needs and desires.

FSSA/DMHA expects the following standards are maintained for AMHH members living in a FSSA/DMHA certified residential setting (specific information regarding standards for FSSA/DMHA certified residential facilities can be found in 440 IAC 7.5, *Residential Living Facilities for Individuals with Psychiatric Disorders or Addictions*):

- Individual/single occupancy dwellings or residences which support multiple individuals.
- FSSA/DMHA certified residential settings in which some individuals may choose to live will promote opportunities to assist and support each individual to grow and develop skills needed to continue to live in the community.
- While in a FSSA/DMHA certified residential facility, the provider's responsibility is to ensure the resident's involvement in decisions that affect his/her care, daily schedules and lifestyles.
- The overall atmosphere of the setting is conducive to the achievement of optimal independence, safety and development by the resident with his/her input.
- The location of the facility is made to provide residents reasonable access to the community at large including but not limited to agency, medical, recreational, and shopping areas, by public or agency-arranged transportation.
- The location, design, construction, and furnishings of each residence shall be consistent with a family/personal home (home-like).
- The majority of services and behavioral health care is provided in locations outside of the residence, such as in the community at large or in a clinic setting.
- Residents are afforded the opportunity to engage in community-based programs that assist the individual in achieving goals including employment.

Within AMHH, the State defines *homelike*, to the extent feasible, as an atmosphere with patterns and conditions of everyday life that are as close as possible to those of individuals without a diagnosis of mental illness. This includes an environment designed with the purpose and focus to increase the resident's involvement in decisions that affect his/her care, daily schedules and lifestyles to be more similar to his/her peers who live on their own. The overall atmosphere of the setting is conducive to the achievement of optimal development of independence by the residents. The location of the facility is made to provide residents reasonable access to the community at large including but not limited to the agency, medical, recreational, and shopping areas by public or agency-arranged transportation.

An AMHH member living in a FSSA/DMHA certified residential setting has the following rights as documented in **440 IAC 7.5** :

- The environment is safe.
- Each resident is free from abuse and neglect.
- Each resident is treated with consideration, respect, and full recognition of the resident's dignity and individuality.
- Each resident is free to communicate, associate, and meet privately with persons of the resident's choice, as long as the exercise of these rights does not infringe on the rights of another resident and any restriction of this right is a part of the resident's individual treatment plan;
- Each resident has the right to confidentiality concerning personal information including health information.

- Each resident is free to voice grievances and to recommend changes in the policies and services offered by the agency.
- Each resident has the right to manage personal financial affairs or to seek assistance in managing them, unless the resident has a representative payee or a court appointed guardian for financial matters.
- Each resident shall be informed about available legal and advocacy services, and may contact or consult legal counsel at the resident's own expense.
- Each resident shall be informed of FSSA/DMHA's toll free consumer service line number.
- Each resident shall begin receiving AMHH services within a timely manner from the date of approval for services.
- Each resident has the right to privacy in their sleeping or living unit.
- Each resident has the right to units having lockable entrance doors, with appropriate staff having keys to doors.
- When sharing living units, each resident has a choice of roommates.
- Each resident has the freedom to furnish and decorate their sleeping or living units.
- Each resident is able to have visitors of their choosing at any time.
- The setting is physically accessible to each resident.
- Each resident will be free from restraints, restrictive interventions, and seclusion.

Any modification of the resident's rights must be supported by a specific assessed need and documented in the person-centered IICP.

The community residential settings certified by FSSA/DMHA and identified in the SPA as meeting the standard for community living include:

- a supervised group living facility.
- a transitional residential services facility.
- a semi-independent living facility defined under IC 12-22-2-3.
- alternative family homes operated solely by resident householders.

SUPERVISED GROUP LIVING FACILITY (SGL)

A *supervised group living facility* is defined by FSSA/DMHA as a residential facility that provides a therapeutic environment in a home-like setting to persons with a psychiatric disorder or addiction who need the benefits of a group living arrangement as post-psychiatric hospitalization intervention or as an alternative to hospitalization. "Therapeutic environment" means a living environment in which the staff and other residents contribute, and that presents no physical or social impediments to the habilitation and rehabilitation of the resident. This setting is designed to assist individuals in their recovery process by offering a safe, supportive, home-like environment. On-site supervision is required 24 hours a day/7 days a week (24/7) in this setting. Individuals may come and go as needed to attend work/school, treatment appointments, recreation, etc. While individuals would have access to food 24/7, there are typically planned meal times where individuals may eat together. Menus are developed by dieticians to provide healthy meals that are consistent with each individual's dietary needs/restrictions (e.g. diabetic, low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Consumers are given input in the meal planning process. A certified supervised group living facility serves up to ten (10) consumers in a single family dwelling and up to fifteen (15) consumers in an apartment building (3 or more living units) or in a congregate residence.

TRANSITIONAL RESIDENTIAL FACILITY (TRS)

A *transitional residential facility* is defined by FSSA/DMHA as a 24-hour per day service that provides food, shelter, and other support services to individuals with a psychiatric disorder or addiction who are in need of a short-term supportive residential environment. Individuals in this setting are likely preparing for, or already participating in, work or school activities. Individuals in this type of setting are provided with less than 24-hour supervision. They have input into household activities and may come and go as needed to attend work/school, treatment appointments, recreation, etc. While individuals would have access to food 24/7, there are typically planned meal times where individuals may eat together. Menus are developed by dieticians to provide healthy meals that are consistent with each individual's dietary needs/restrictions (e.g. diabetic, low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Consumers are given input in the meal planning process. A certified transitional residential facility serves fifteen (15) or fewer persons.

SEMI-INDEPENDENT LIVING FACILITY (SILP)

A *semi-independent living facility* is defined by FSSA/DMHA as a facility:

- that is not licensed by another state agency and serves six (6) or fewer individuals who have a psychiatric disorder or an addiction, or both, per residence, who require only limited supervision; and
- in which the agency or its subcontractor provides a resident living allowance to the resident; or owns, leases, or manages the residence.

These settings are typically home-like. This setting is intended to prepare individuals for independent living settings. Individuals in this type of setting are provided with a minimum of oversight (i.e., one hour per week). Individuals have input into household activities and may come and go as needed to attend work/school, treatment appointments, recreation, etc. While individuals would have access to food 24/7, there are typically planned meal times where individuals may eat together. Menus are developed by dieticians to provide healthy meals that are consistent with each individual's dietary needs/restrictions (e.g. diabetic, low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Consumers are given input in the meal planning process.

ALTERNATIVE FAMILY FOR ADULTS (AFA) PROGRAM

An *alternative family for adults program* is defined by FSSA/DMHA as a program that serves six (6) or fewer individuals who have a psychiatric disorder or addiction, or both, and reside with an unrelated householder. These settings are home-like. This setting is intended to prepare individuals for independent living settings; or may become permanent housing if this best meets the individual's needs and a less restrictive setting is not wanted or deemed appropriate by the individual or treatment team. Individuals in this type of setting are provided with a minimum of oversight (i.e., two hours per month). Individuals have input into household activities and may come and go as needed to attend work/school, treatment appointments, recreation, etc. While individuals would have access to food 24/7, there are typically planned meal times where individuals may eat together. Menus are developed by dieticians to provide healthy meals that are consistent with each individual's dietary needs/restrictions (e.g. diabetic, low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Consumers are given input in the meal planning process. The program serves six (6) or fewer residents.

STATE MONITORING

FSSA'S DMHA retains the authority to monitor and enforce the adherence to standards by conducting on-site visits to ensure compliance with standards and respond to any complaint or incident reported. In addition to consumer feedback and site visits, data is collected and analyzed per the Quality Indicator section of the AMHH SPA. There are also facility requirements for compliance with fire and safety codes which must be kept up to date. FSSA/DMHA will conduct site visits to ensure standards are met.

Individuals residing in any FSSA/DMHA certified residential setting have the freedom to choose how they live and residents' rights are respected and honored.

SECTION 7: AMHH REFERRAL AND APPLICATION PROCESS

In order for an individual to receive AMHH services, a FSSA/DMHA-approved AMHH provider agency, in collaboration with the individual seeking services, must refer the individual for evaluation by the SET via a web-based application process in the manner required by FSSA (FSSA/OMPP and FSSA/DMHA). AMHH services will not be authorized for any individual who has not successfully completed the AMHH application process or does not meet all AMHH eligibility criteria, as determined by the FSSA/DMHA SET. This manual section outlines the referral process and provider agency responsibilities during the application process. Specific instructions for completing the AMHH application are provided in the next section.

REFERRALS FOR AMHH SERVICES

Referrals to AMHH services may come from any source within the community:

- CMHCs or other treatment providers may identify individuals who appear to meet the AMHH target group and needs-based eligibility criteria.
- Individuals may notify a FSSA/DMHA-approved AMHH provider of an interest in AMHH services.
- Family members or caregivers may inquire about the services and assist their family member in contacting a FSSA/DMHA-approved AMHH provider.

Note: The AMHH referral process may begin while an applicant is in an institutional setting (e.g., SOF) as a part of discharge planning and continuity of care. However, AMHH services may not begin until the individual has been discharged to a community-based setting.

Information about AMHH services may be obtained on the FSSA/DMHA public website at http://www.in.gov/fssa/dmha/2876.htm. The website provides a summary of the eligibility criteria and a description of all available AMHH services, as well as a list of AMHH service provider agencies, locations where potential enrollees may go to apply, and information about how to access AMHH assessments or services. In addition, any individual may contact the state for information about AMHH eligibility and the process to apply. In those cases, the individual is given a list of FSSA/DMHA-approved AMHH provider agencies that may be chosen to assist in the application process.

Prior to completing the AMHH application processes, the FSSA/DMHA-approved AMHH provider will explain the benefits and purpose of the AMHH program and services with the interested applicant. Next, the provider will assist in identifying whether or not the applicant meets the AMHH target group and needs-based criteria. If the applicant meets initial eligibility criteria and is interested in pursuing application for AMHH services, the AMHH provider will work with the applicant to complete the AMHH application process.

PROVIDER AGENCY RESPONSIBILITIES DURING THE APPLICATION PROCESS

INFORMED CHOICE OF PROVIDERS

The FSSA/DMHA-approved AMHH provider agency is responsible to inform the applicant of their right to select an AMHH provider of their choice for provision of AMHH services. During the AMHH application process, the provider agency is responsible for performing the following tasks and documenting the activities intended to educate the applicant regarding informed choice of providers:

- Explain the applicant's right to an *informed choice of providers* (meaning the applicant is informed of their right to interview potential service providers and make their own choice regarding which AMHH provider agency, and which service provider staff within that agency, what family members/caregivers , will provide the AMHH services documented on the proposed IICP or be involved as a member of the individuals team.).
- Provide a listing of FSSA/DMHA-approved AMHH provider agencies both within and contiguous to the applicant's county of residence. The agency will provide a randomized list of FSSA/DMHA-approved AMHH provider agencies for the applicant to select from when developing the application and document via an attestation in the AMHH application.
- Applicant is informed that an AMHH provider agency listing is also posted on the Indiana FSSA/DMHA AMHH website http://www.in.gov/fssa/dmha/2876.htm.
- Applicant is informed of their right to elect to change an AMHH provider staff or provider agency at any time during their AMHH program eligibility period. The current AMHH provider is expected to assist the individual in transitioning service delivery to the newly selected AMHH provider.

Requirement for Face-To-Face Evaluations

Every AMHH applicant is required to receive an individual face-to-face evaluation as the foundation of the application process, using both the FSSA/DMHA-approved behavioral health assessment tool (ANSA) and the application form developed by FSSA (FSSA/OMPP and FSSA/DMHA). A comprehensive biopsychosocial evaluation is conducted by provider agency staff qualified to conduct AMHH assessments (see below). The results of the evaluation and the ANSA assessment are included with the AMHH application. Documentation of the individual face-to-face evaluation in the applicant's medical record must include the following:

- Review, discussion and documentation of the applicant's desires, needs, and goals. Goals are habilitative in nature with outcomes specific to the habilitative needs identified by the applicant.
- Review of psychiatric symptoms and how they affect the applicant's functioning and ability to attain desires, needs and goals.
- Review of the applicant's skills and the level of support needed for the applicant to participate in a long-term recovery process, including stabilization in the community and ability to function in the least restrictive living, working, and learning environments.
- Review of the applicant's strengths and needs, including medical, behavioral, social, housing, and employment.

Only qualified and trained staff from FSSA/DMHA-approved AMHH provider agencies may conduct the face-to-face evaluation required for the AMHH application process. The AMHH provider agency must ensure that the agency staff member providing the face-to-face AMHH evaluation meets the following minimum qualifications:

- Possesses at least a bachelor's degree in social sciences or related field, with two (2) or more years of clinical experience.
- Has completed the FSSA (FSSA/DMHA and FSSA/OMPP) approved training for AMHH eligibility determination, application process, and service delivery standards. It is the responsibility of the CMHC to ensure appropriate documentation is in the staff file demonstrating compliance with training requirements.
- Is a certified Adult Needs and Strengths Assessment (ANSA) user receiving supervision from an ANSA SuperUser.

Behavioral Health Assessment Tool

The Adult Needs and Strengths Assessment (ANSA) is the FSSA/DMHA-approved behavioral health assessment tool used to identify an applicant's strengths and needs at the time of application, and is used to assist in the identification of an individual's level of need for AMHH services. The tool consists of items grouped into categories (domains) that the provider agency staff member will assess and discuss with the applicant during the face-to-face biopsychosocial assessment. The combined ratings resulting from the completed ANSA tool generate a level of care recommendation that may be used to support an AMHH recommendation for services.

The level of need recommendation from the ANSA tool is not intended to be a mandate for the level of services that an individual will receive, but is one element used in the final eligibility decision made by the SET. There are many factors, including an individual's preferences and choice, which influence the actual intensity of the treatment services recommended on the applicant's proposed IICP.

> The DMHA-approved behavioral health assessment tool (ANSA) must be completed and submitted in DARMHA within ***sixty (60) days*** of submitting the initial or renewal AMHH application to be considered current. Data from the most recent ANSA at the time the application is created becomes populated in the AMHH application, regardless of the "age" of that ANSA. If the ANSA is more than sixty (60) days old the application will be denied by the SET.

Providers may obtain additional information about the ANSA tool, training, support and certification by contacting FSSA/DMHA. The ANSA user's manual may be found online at: https://dmha.fssa.in.gov/DARMHA/Documents/ANSAManual_712011.pdf.

Proposed AMHH Plan of Care

The agency provider staff member and the applicant as well as those individuals the applicant choses to be an active part of their team, will jointly develop a proposed Individualized Integrated Care Plan (IICP) that includes identified strengths, needs, applicant's desired goals and choice of providers and services (including proposed AMHH services) deemed necessary to address the documented goals. Refer to *Section 9: Person-Centered Planning and Individualized Integrated Care Plan Development* for additional information regarding person-centered planning and the AMHH IICP requirements and expectations.

Completion and Processing of the AMHH Member Application

The AMHH agency provider staff member will complete and submit the AMHH application via FSSA/DMHA's web-based Data Assessment Registry Mental Health and Addiction (DARMHA) system. The application must be complete and submitted in its entirety for eligibility determination by the SET. Elements of the AMHH application include:

- Applicant identifying and eligibility information
- Description of the Living Situation
- Justification of Need for AMHH service
- Strengths
- Needs

- Goals
- Objectives
- Requested Services
- Attestations

> **Note:** The AMHH application must be submitted with attestations that the required signatures have been obtained. The required signatures must be maintained in the AMHH member's clinical record, and are subject to review by SET during AMHH quality assurance site visits.

Further information about the required attestations, as well as instructions on how to complete the application are provided in *Section 8: Completing the AMHH Application.*

Once a complete AMHH application is submitted through DARMHA, the SET evaluates the application and determines whether the applicant meets eligibility for the AMHH program. Eligibility determinations for the AMHH program are made exclusively by the SET to avoid any potential conflicts of interest. See *Section 10: AMHH Eligibility Determination, Service Approval and Utilization* for specific information about SET determinations.

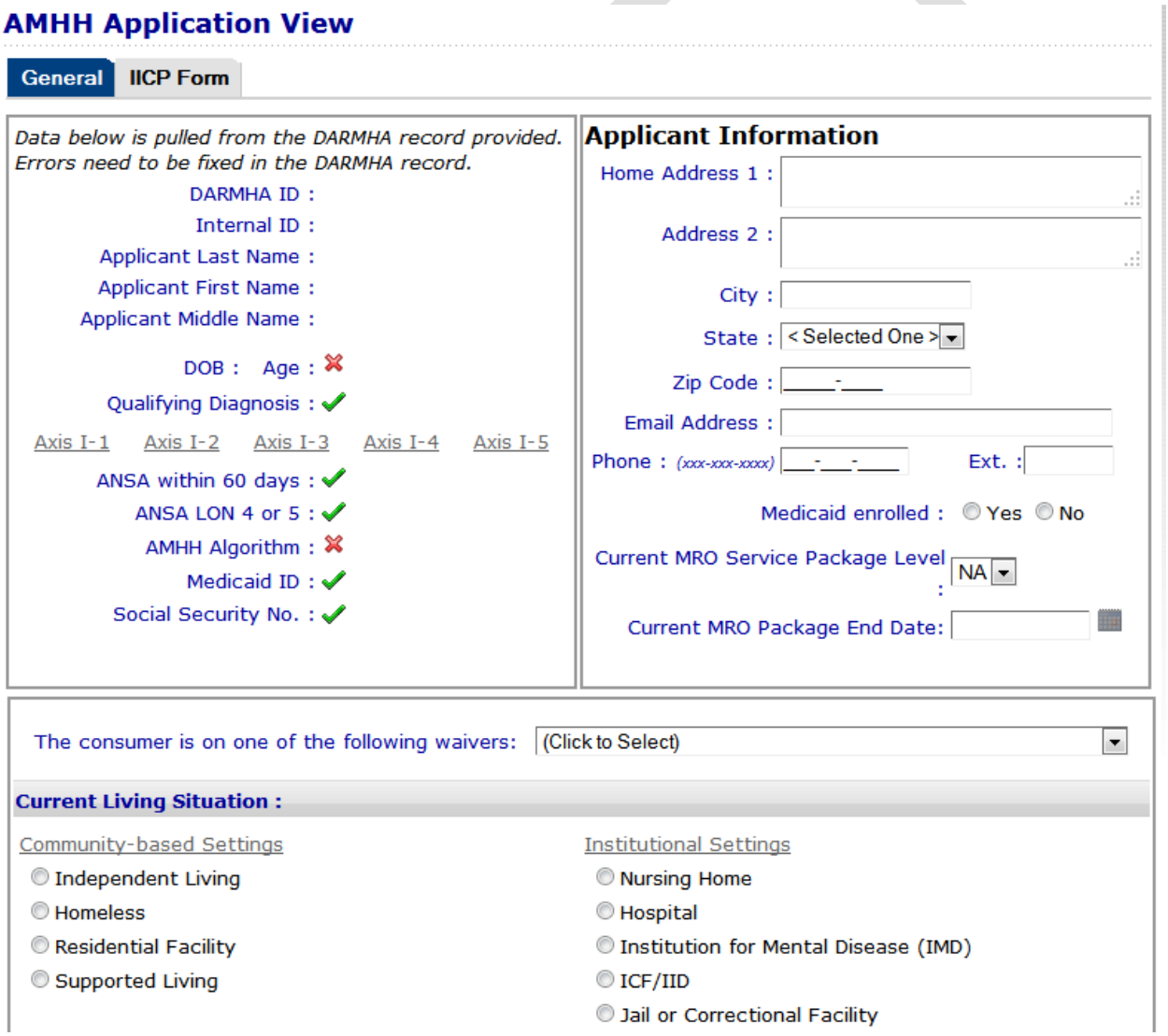
SECTION 8: COMPLETING THE AMHH APPLICATION

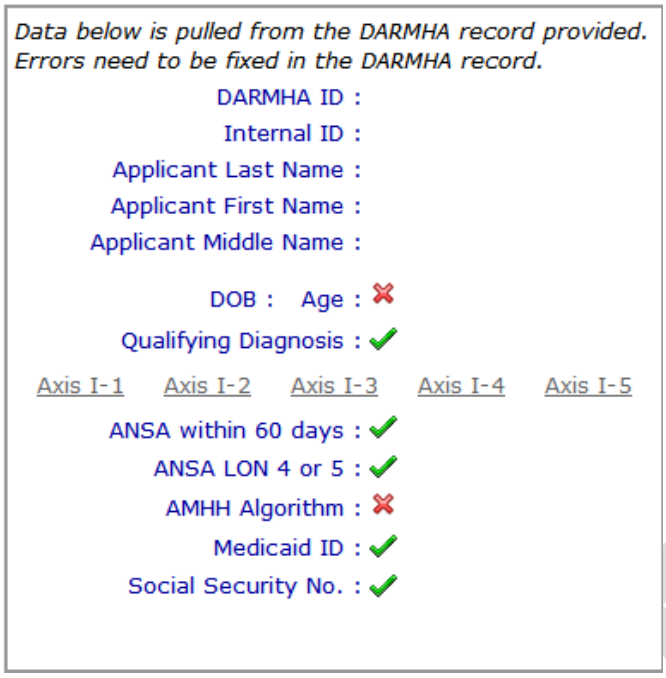
In order for an individual to receive AMHH services, an AMHH provider agency, in collaboration with the individual seeking services, must submit an application in the manner required by FSSA (FSSA/OMPP and FSSA/DMHA). This manual section provides instructions for completing the AMHH application in DARMHA.

ELEMENTS OF THE AMHH APPLICATION

PAGE 1 - GENERAL

This is a screenshot of the upper half of the first page of the application. The information required in each section is described in detail below:

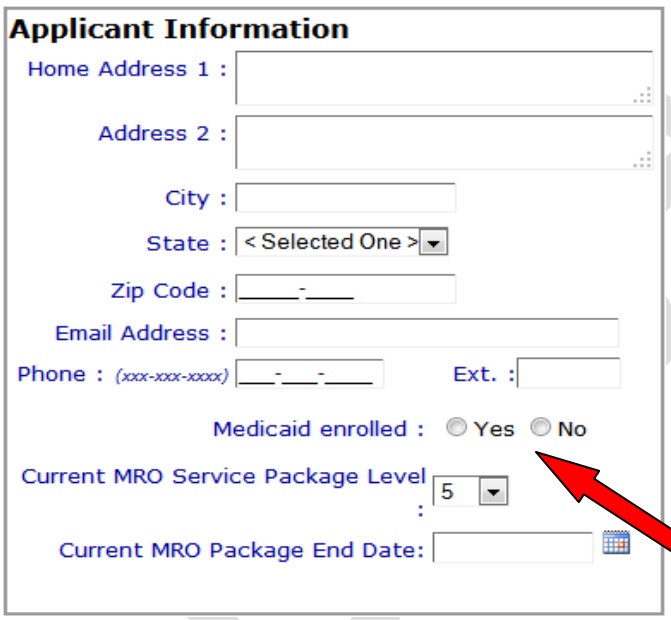




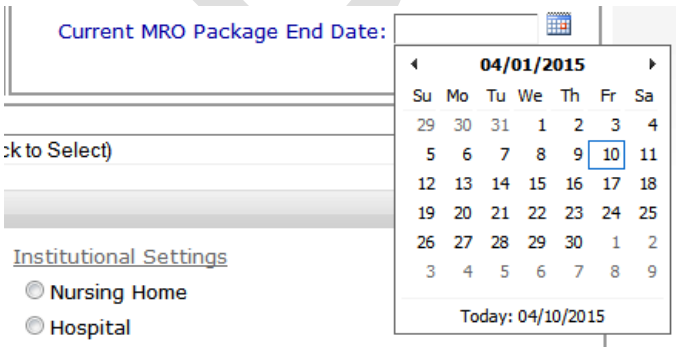
Information in the top left box is automatically imported from the consumer's DARMHA record, so all of that information should be checked for accuracy and, if necessary, corrections made before submission.

Please note: A **GREEN check mark** next to an item means the AMHH eligibility criteria is met for that item.

A RED "X" means the AMHH eligibility criteria is not met for that item.

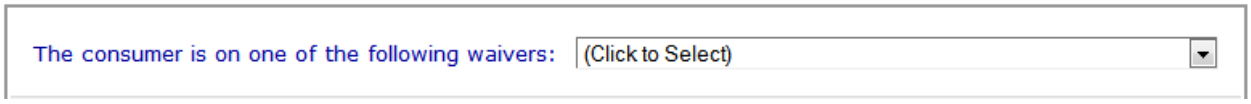


Applicant Information: The current home address and telephone number must be entered in the AMHH application (please note, consumer's email address is NOT required). This is the home mailing address to which the consumer's AMHH approval or denial notice is sent; therefore, it is critical that this information is accurate. Consumers must be asked their preferred address to receive AMHH notices. If the consumer is homeless or does not have an address to provide, the CMHC address may be entered, if the consumer consents.



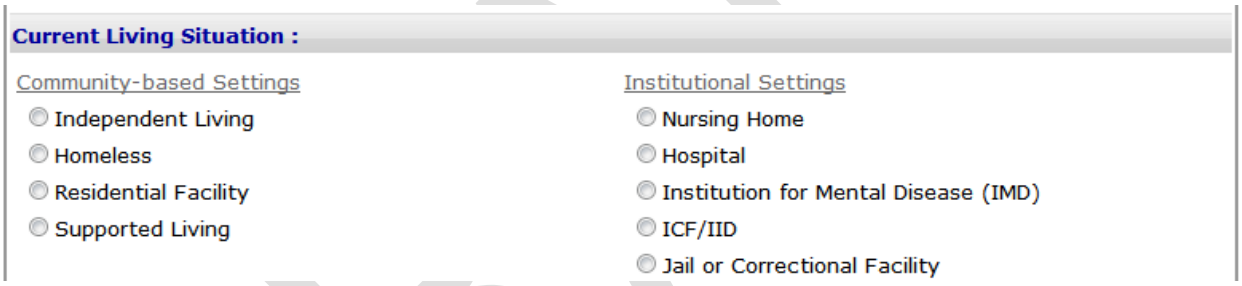
When "YES" is selected for the *Medicaid enrolled* item, the *Current MRO Service Package Level* must be selected from the pull-down menu.

The *Current MRO Package End Date* field is required if MRO Service Package Level 3, 4, 5, or 5A is chosen, and a calendar box will pop up to assist.



HCBS Waiver: A consumer must be asked if he or she is participating in a HCBS waiver. As described further in *Section 2*, AMHH service providers are responsible, in collaboration with waiver providers, for monitoring services of AMHH members also enrolled in a 1915(c) waiver to prevent service duplication. The AMHH provider must select from the following options, using the pull-down menu:

- Community Integration and Habilitation Waiver
- Family Supports Waiver
- Aged and Disabled Waiver
- Traumatic Brain Injury Waiver
- Money Follows the Person
- Consumer is on waiver, unsure which waiver
- Unknown whether consumer is on waiver. (*NOTE*: this should be selected only if the question has been asked of the applicant, and he or she is uncertain. All AMHH applicants must be asked this question.)
- Not on a waiver



Current Living Situation: The check box next to the applicable current living situation, as described below, is entered on the application.

Home and Community-Based Settings are defined as the following:

- Independent Living: Living with non-foster family without supportive community service being received in the home setting; living in a house, apartment, trailer, hotel, dormitory, barrack, single-room occupancy, or in the residence of parents, relatives, legal guardians, or other primary caregivers; no routine or planned supportive community service intervention received to maintain independence in the living situation.
- Homeless: Homeless, alone or with family: A person is considered homeless if he or she lacks a fixed, regular, and adequate nighttime residence or his or her primary nighttime residence is (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations for a period of three months or less; (b) an institution that provides a temporary residence for individuals intended to be institutionalized; or (c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (for example, on the street).
- Residential Facility: Twenty-four hours a day, seven days a week; may include short and long-term residential placement including supervised group home, board and care, room, board and

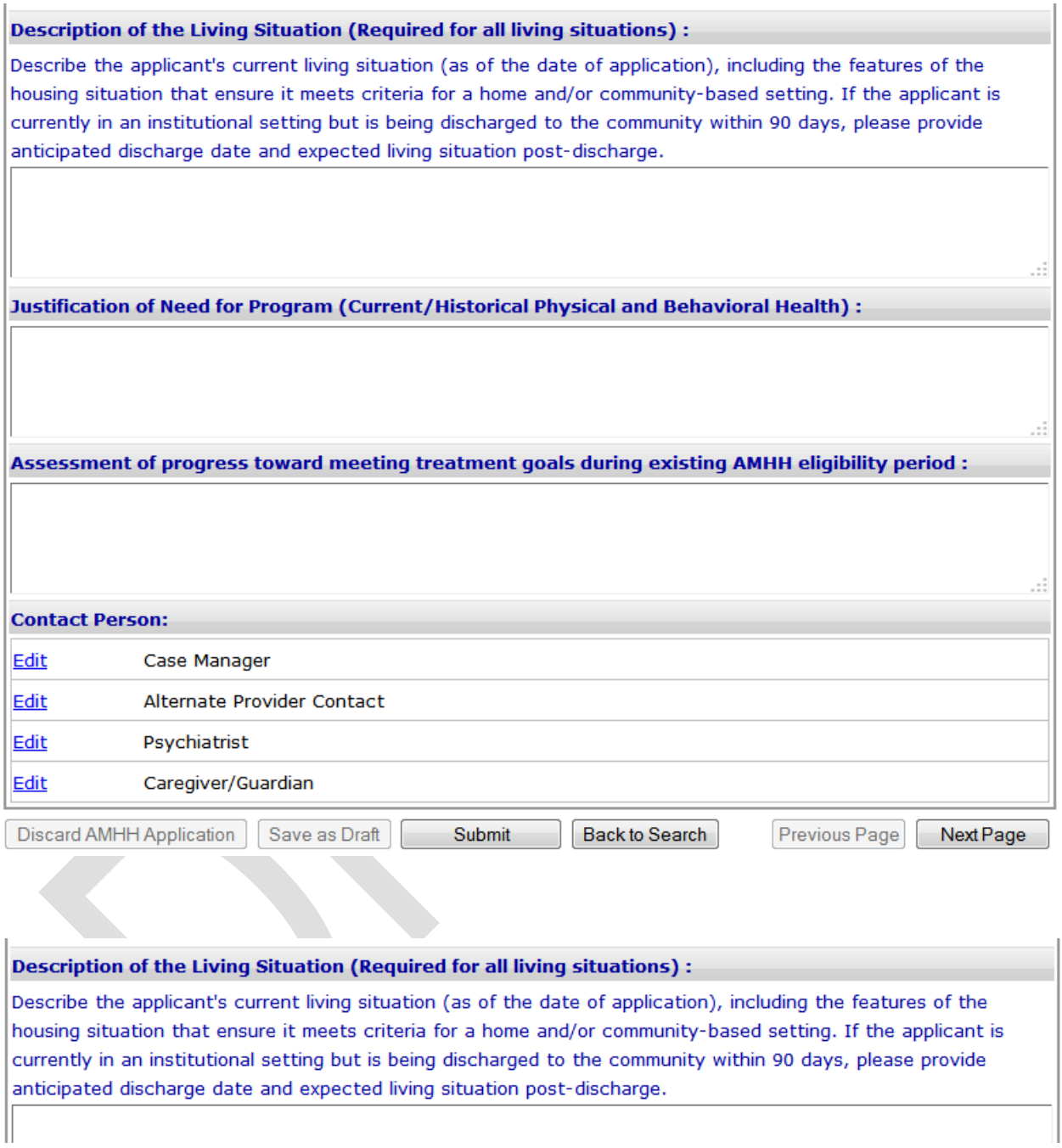
assistance (RBA), rehabilitation center, halfway house, therapeutic group home, agency-operated residential care facilities.

- Supported Living: Living with non-foster family and receives supportive community service in the home setting; living in a house, apartment, trailer, dormitory, barrack, single-room occupancy, or in the residence of parents, relatives, legal guardians, or other primary caregivers; receives routine of planned supportive community services and/or financial support for the living arrangement. Includes semi-independent living. There is community support services intervention.
    - *Note: Supportive community services are individualized services to promote recovery, manage crises, perform activities of daily living, and manage symptoms, and are not public entitlements. Public entitlements are funding sources that a consumer qualifies for based on income, disability, and so on. Public entitlements include, but are not limited to, Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP). Consumers can be receiving public entitlements and be considered living independently.*

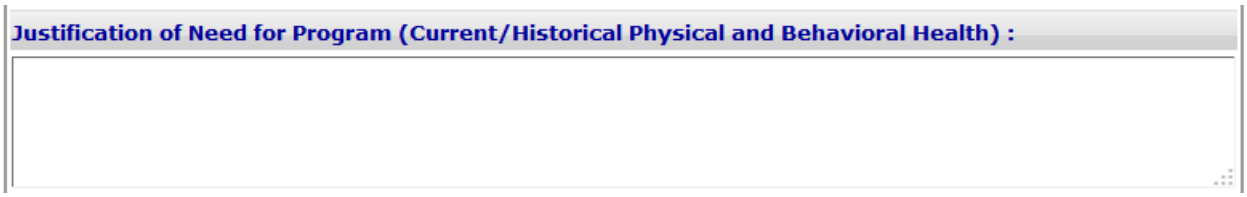
<u>Institutional Settings are defined as the following:</u>

- Nursing Home: Twenty-four hours a day, seven days a week care in a skilled nursing facility.
- Hospital: Twenty-four hours a day, seven days a week care; inpatient psychiatric hospital, psychiatric health facility (such as a stress center), general hospital, private adult psychiatric hospital, Veterans Affairs hospital, state-operated facility (SOF), or transitional care hospitals.
- IMD: Institute for Mental Disease.
- Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID): Twenty-four hours a day, seven days a week care in an intermediate care facility for individuals with intellectual disabilities.
- Jail/Correctional Facility: Home detention, detention centers, work release, weekend jail, boot camp, jail, correctional facility, prison.
-

This is a screenshot of the lower half of the first page of the application. The information required in each section is described in detail below:



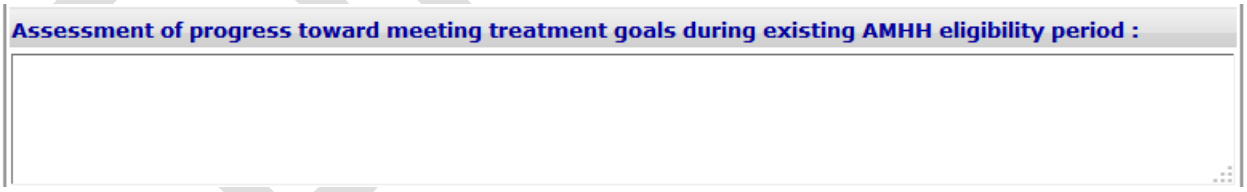
Description of the Living Situation: **REQUIRED FOR ALL LIVING SITUATIONS!!** Applicants must be currently living in a CMS home and community-based setting, OR they may be in an institutional setting as long as an anticipated discharge date is within 90 days and the applicant will be discharged to a home or community based setting. The anticipated discharge date must be included in this section.



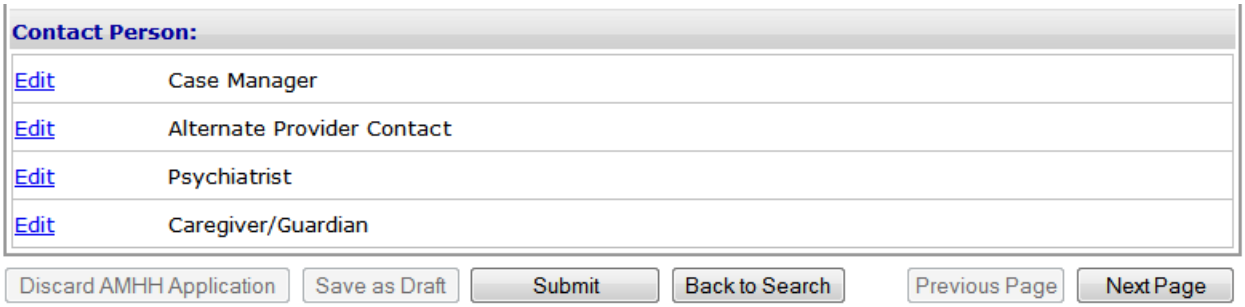
Justification of Need for Program: This section is crucial for establishing how and why the consumer will benefit more from a habilitative approach to care, rather than a rehabilitative approach. The narrative may resemble a condensed biopsychosocial summary, and must establish and demonstrate that the applicant meets the AMHH target and needs-based criteria. It may include (but is not limited to) the following information:

- Historical and current health status
- Behavioral health issues
- Current living situation
- Functional needs
- Family functioning
- Vocational/employment status
- Social functioning
- Living skills
- Self-care skills
- Capacity for decision making
- Potential for self-injury or harm to others
- Substance use/abuse
- Experience and response to rehabilitative services and the outcomes from those services
- Medication adherence

Information regarding the applicant's participation in any prior rehabilitative services and the outcomes from participation in those services must also be documented in this section of the application.



Assessment of progress toward meeting treatment goals during existing AMHH eligibility period: This narrative box only appears on renewal applications, for those members who are already enrolled in AMHH and are applying for another annual eligibility period. See *Section 12* for additional information about what is expected to be included in this narrative box.

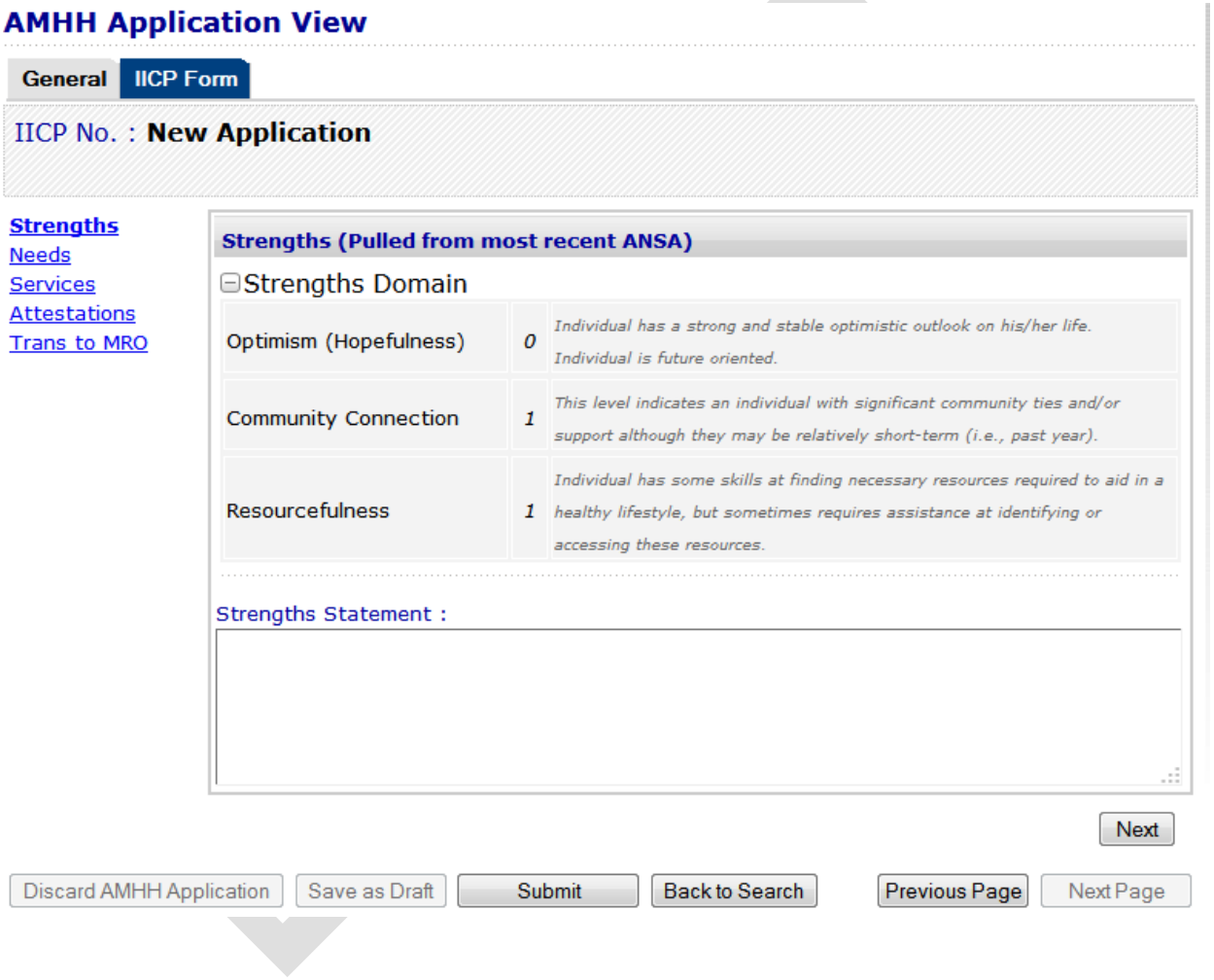


Contact Person: Primary and alternate case managers as well as the attending psychiatrist must be identified. Caregiver/Guardian must be completed where applicable. Click Edit next to each member role, enter their name, phone number, and email, and then click Update to save the information. The application may not be submitted until all required information is entered.

PAGE 2 – IICP FORM

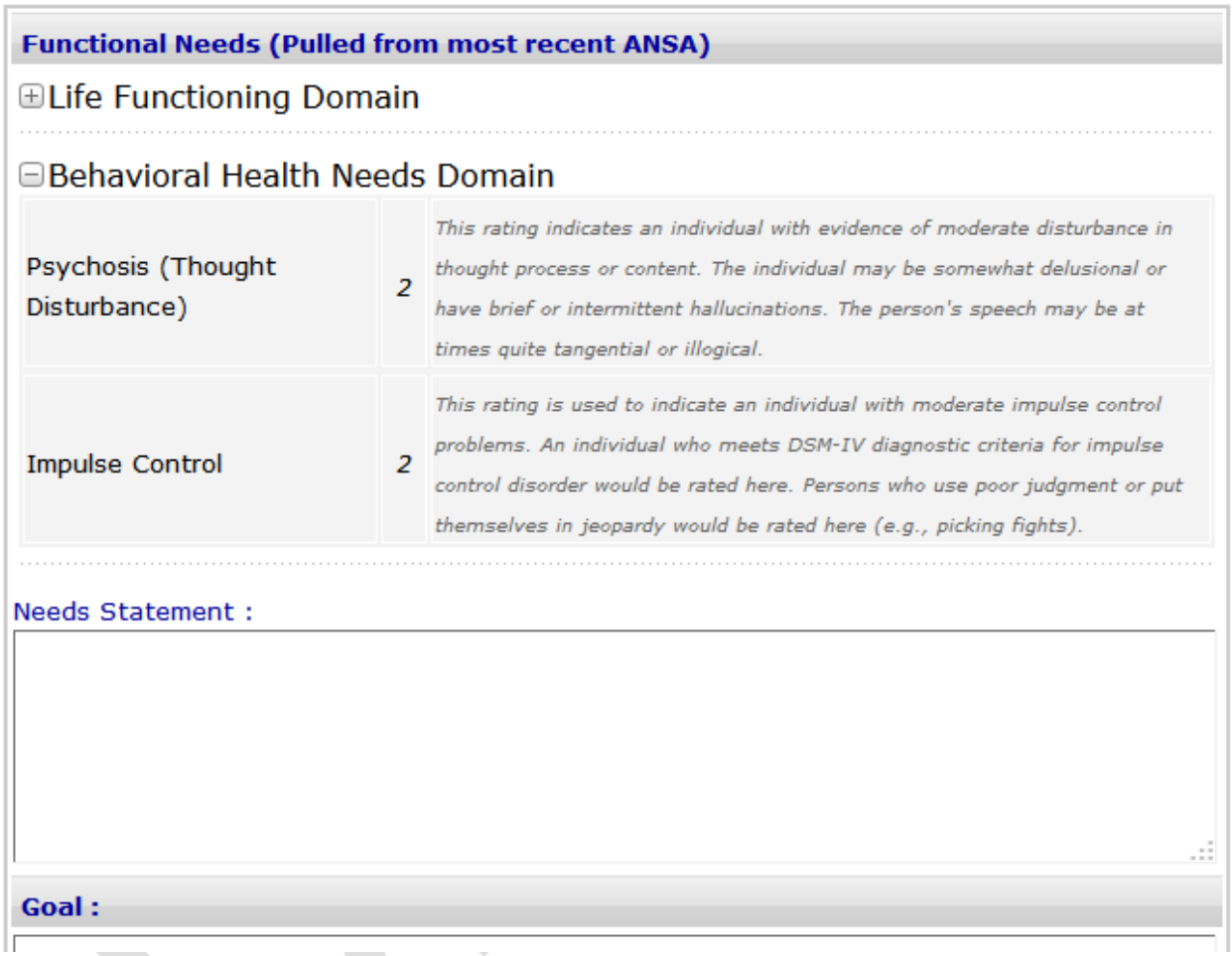
Following are screenshots of each section of the second page of the application – IICP Form. The sections are accessed by clicking on the blue underlined "wizard" links on the left side of the application.

Strengths: Below is an expanded view of the Strengths wizard. It displays all items imported from the Strengths domain of the ANSA attached to the application that were scored as a 0 or 1, indicating the most stable and useful strengths identified by the applicant. **The person completing the application must provide a narrative summary ("Strengths Statement", below) of the most relevant and supportive strengths that the applicant has available when living in the community.**



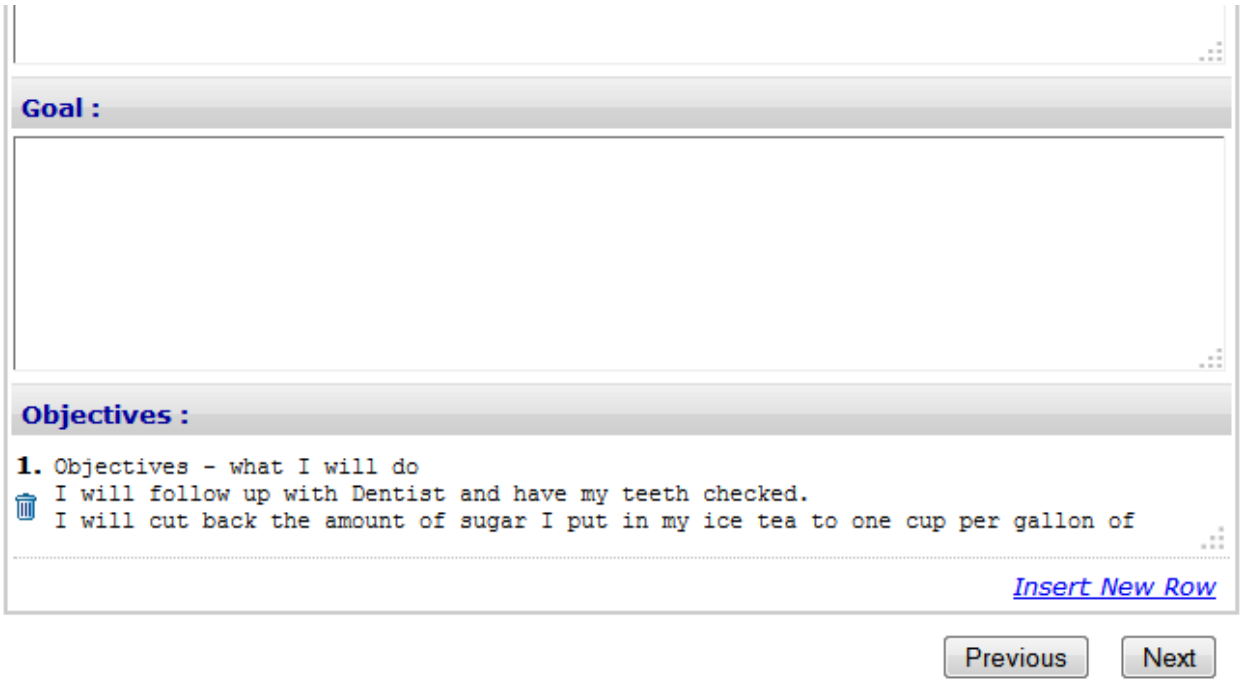
The display may be toggled between expanded and collapsed views by clicking on the plus (to expand) or minus (to collapse) sign next to "Strengths Domain".

Functional Needs: Below is a partially expanded view of the Needs wizard. It displays all items imported from the Life Functioning, Acculturation, Behavioral Health Needs, and Risk Behaviors domains of the ANSA attached to the application that were scored as a 2 or 3, indicating the most troubling or problematic needs areas identified by the applicant. **The person completing the application must provide a narrative summary ("Needs Statement", below) of the 3-4 most immediate, significant, or impairing needs the applicant faces regularly when living in the community.**

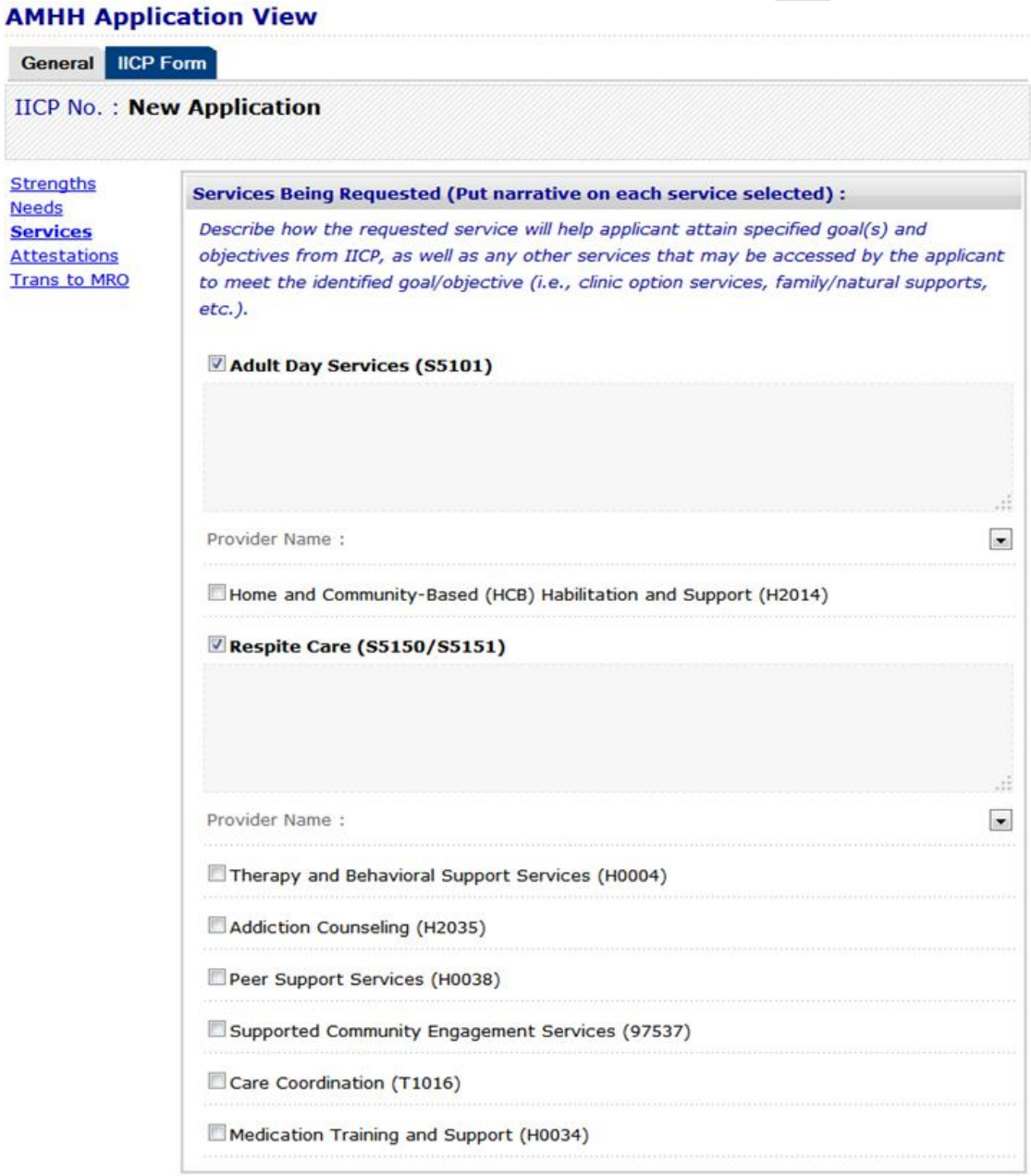


The display may be toggled between expanded and collapsed views by clicking on the plus (to expand) or minus (to collapse) sign next to each Functional Need domain.

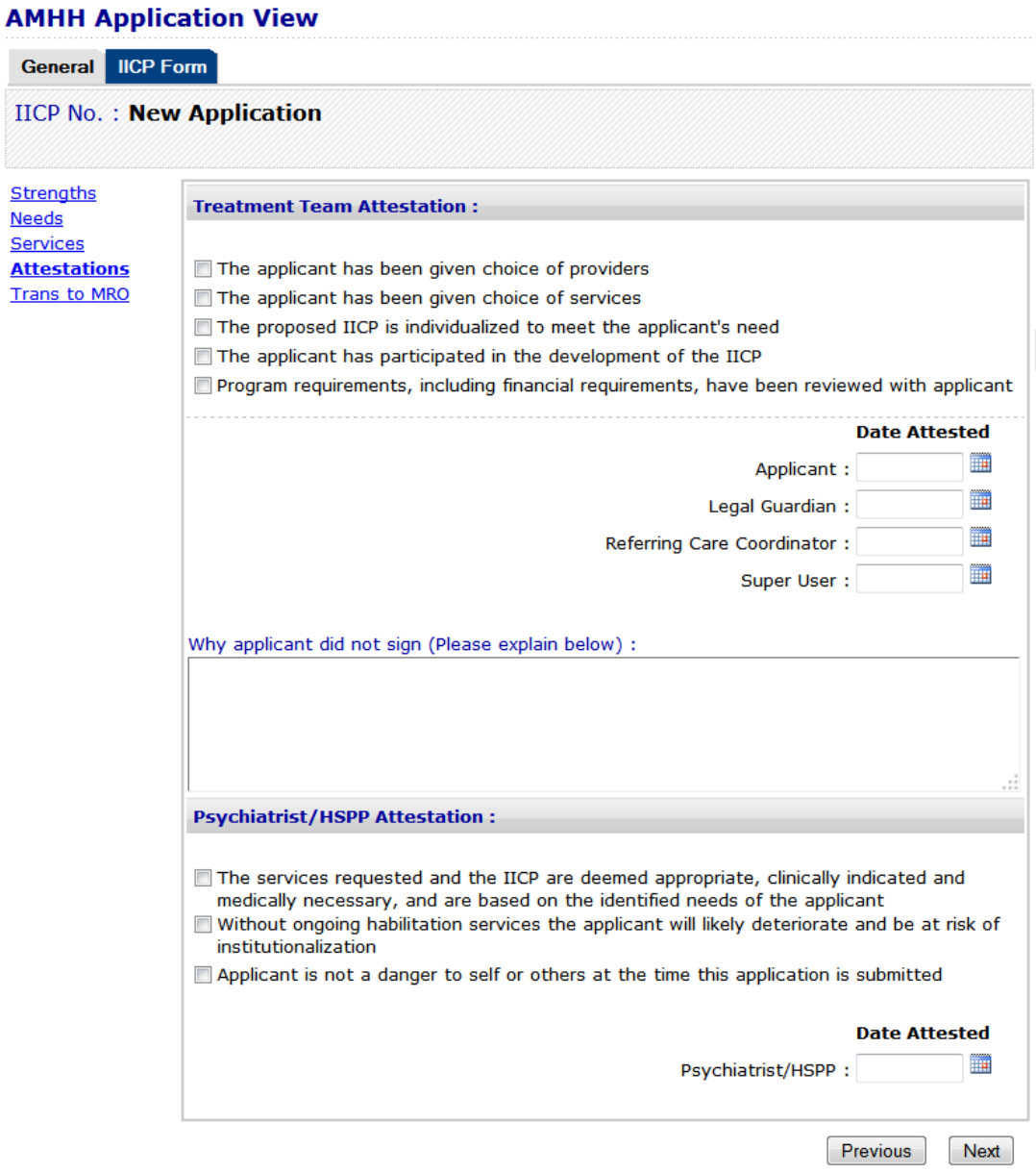
Goal and *Objectives* narrative boxes: Goals and objectives for AMHH applicants and members must be habilitative in nature. They are intended to promote stability and potential movement toward independence and integration into the community, treatment of mental illness symptoms, and habilitating areas of functional deficits related to the mental illness. Goals are ideally presented in the consumer's own words, and must reflect the consumer's desires and choices. Objectives are intended to support maintenance of previously learned skills and preservation of the individual's current (best) level of functioning.



Services: Each service requested by and on behalf of the applicant is selected here. Additional information about the scope of each service is provided in *Sections 15-23*. For each service selected, **the person completing the application must provide a narrative summary of how the service will help the applicant attain one or more of the goals and objectives specified in the previous section of the IICP.** All IICPs must be developed with the applicant and individualized to meet their identified needs (refer to *Section 9* for additional information on IICP development). The "Provider Name" will default to the provider agency submitting the application. If the applicant chooses a different provider agency to provide the requested service(s), the chosen agency must be selected from the "Provider Name" pull-down menu.



Attestations: There are eight required activities that must be completed prior to the application being submitted. Included in the application is the required acknowledgement that the following attestations have been fulfilled and signed. The date the signatures were obtained by the applicant, legal guardian (if applicable), referring care coordinator, ANSA Super User, and attending psychiatrist/HSPP must be entered on the application. AMHH provider agencies must maintain the actual documentation with signatures in the clinical record.



Hard copy or electronic signatures from the applicant, case manager, legal guardian (if applicable), reviewing ANSA SuperUser, and attending psychiatrist/HSPP **must** be kept in the consumer's clinical chart and made available for review by the State Evaluation Team during quality assurance site visits. The date of the signature on the attestation must match the date of attestation entered on the AMHH application.

A description of each attestation, and who must sign for verification, follows:

- The applicant has been given choice of providers. This applies to choice in both the provider agency and providers within an agency itself. **Applicant and case manager/referring care coordinator** must sign.
- Individual has been given choice of services to be provided. **Applicant and case manager/referring care coordinator** must sign.
- The proposed IICP is individualized to meet the applicant's needs. **Applicant and case manager/referring care coordinator** must sign.
- The applicant has participated in the development of the IICP. Applicant's attestation verifying his/her participation in the development of the IICP and determining which AMHH services will be included on the plan of care. **Applicant and case manager/referring care coordinator** must sign.
- Program requirements, including financial requirements, have been reviewed with applicant. **Applicant and case manager/referring care coordinator** must sign.
- The services proposed on the IICP are deemed appropriate and medically necessary by the appropriate authority. **Psychiatrist or HSPP** must sign.
- Psychiatrist or Health Services Provider in Psychology (HSPP) attestation regarding the imminent likelihood that without ongoing habilitation services the applicant will likely deteriorate and be at risk of institutionalization (e.g. acute hospitalization, State hospital, nursing home, jail). **Psychiatrist or HSPP** must sign.
- Applicant is not a danger to self or others at the time this application is submitted. **Psychiatrist or HSPP** must sign.

Note: In addition to the attestations noted above, a signature from the ANSA SuperUser reviewing the ANSA must be documented. The date the SuperUser signs the attestation documenting their review must be entered in the application.

Transition to MRO: This wizard will only be visible after a member's AMHH application is approved by the SET and processed by HP. It is intended for use if a consumer opts to transition to MRO services from AMHH services.

The person completing the application must check the box attesting that an ANSA has been completed **AND SUBMITTED IN DARMHA** within 60 days prior to the request to transition to MRO. That person must also check the "Transition to MRO" box, and enter the date that the member requested to transition to MRO in the "Date of Attestation" field. Brief information as to the reason for the transition must be included in the "Support Summary" narrative box. See *Section 13, Transition from AMHH Services,* for additional information.

> The consumer's attestation of their choice to transition to MRO must be captured via hard copy or electronic signature.

REVIEW AND SUBMISSION OF THE APPLICATION

Upon completion of the AMHH member application (including but not limited to the clinical evaluation, ANSA, electronic application, and proposed IICP), the provider agency staff must review the application in its entirety, to ensure complete and accurate information has been included. Special attention must be paid to the following areas:

- Ensure there is a green check mark by each data element in the applicant data section that is automatically populated from DARMHA. A red "X" by any of the elements indicates that the applicant does not meet criteria and does not meet eligibility for the AMHH program.
- All narrative boxes are complete with sufficient required information.
- All required attestations have been checked and physical signatures obtained prior to application submission. A copy of the signed attestations must be maintained in the AMHH member's clinical record.

The completed, reviewed application is submitted by clicking the SUBMIT button at the bottom of the "IICP Form" page. If there are any outstanding items to be addressed, a warning message will pop up, alerting the staff completing the application that additional items need correction before submission.

If an AMHH application is incomplete, unclear, or has conflicting information, the SET may pend the application and require additional information/documentation from the provider agency. The provider agency has seven (7) calendar days from date the application was pended to submit the required information in DARMHA. In the event that the provider agency does not submit the required information/documentation within seven (7) calendar days, the AMHH application is denied.

To ensure no conflict of interest in the AMHH eligibility determinations, the DMHA SET shall in all cases retain the authority to determine an applicant's eligibility for AMHH services and authorization to utilize AMHH services documented on the approved IICP. Refer to *Section 10*: *AMHH Eligibility Determination, Service Approval and Utilization* for additional information about the SET review of the AMHH application and the eligibility determination and services authorization processes.

SECTION 9: PERSON-CENTERED PLANNING AND INDIVIDUALIZED INTEGRATED CARE PLAN DEVELOPMENT

Person-centered planning is an existing FSSA/DMHA expectation for provider agencies in Indiana. This requirement is supported by CMHC certification rules, requirements for national accreditation, and contracts connected to FSSA/DMHA funding. The member has the freedom to choose who is included in the IICP planning and development process. IICPs require staff and member signatures, as well as clinical documentation verifying the member's participation. This manual section outlines the requirements for the proposed IICP developed during the AMHH member application process and throughout the member's enrollment in AMHH services.

STAFF REQUIREMENTS

All AMHH IICPs are to be developed in collaboration with an AMHH provider agency staff member meeting the following minimum requirements (Refer to *Section 3: AMHH Service Providers* for details regarding minimum staffing requirements):

- Licensed professional
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

The AMHH services psychiatrist or HSPP must be enrolled in the IHCP as a rendering provider and be linked to the AMHH provider agency. The State expects the psychiatrist or HSPP to complete the following:

- Review the AMHH member application and assessment information for accuracy.
- Approve and certify the proposed AMHH diagnosis.
- Attest and deem the recommended AMHH services on the proposed IICP are clinically indicated and medically necessary.
- Attest that without ongoing habilitation services the applicant will likely deteriorate and be at risk of institutionalization (e.g., acute hospitalization, State hospital, nursing home, jail).
- Attest that applicant is not a danger to self or others at the time of this application.

FREEDOM OF CHOICE

The AMHH member has the freedom of choice regarding the following:

- The goals and objectives documented on the proposed IICP.
- The AMHH services requested on the proposed IICP, as supported by the member's documented needs.
- The selection of FSSA/DMHA-approved AMHH service provider(s) who will deliver AMHH services.

Reminder: AMHH members have the right to request a change of AMHH providers at any time during the AMHH eligibility period.

INDIVIDUALIZED INTEGRATED CARE PLAN (IICP) DEVELOPMENT

A proposed AMHH IICP must be developed for each member through a collaboration that includes the applicant/member, identified community supports, family/nonprofessional caregivers, and all individuals/agency staff involved in assessing and/or providing care for the applicant/member. The IICP is a habilitative plan of care that integrates all components and aspects of care that are:

- Clinically indicated and deemed medically necessary.
- Supported by member's identified needs.

- Provided in the most appropriate, least restrictive setting to achieve the applicant/member's goals.
- Includes all indicated medical and support services needed by the recipient in order to remain in the community and function at the highest level of independence possible.

The provider agency staff member must ensure the IICP development is driven by a person-centered planning process that incorporates the following IICP standards:

- Identifies the member's physical and behavioral health support needs, strengths and preferences and desired outcomes.
- Takes into account the extent of, and need for, any family or other supports for the individual.
- Prevents the provision of unnecessary or inappropriate services or care.
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes.
- Reflects a plan of care developed for the member with the member and represents the member's desires and choices for care.

The IICP must include all identified services medically necessary to assist the applicant/member to continue to reside in the community, to function at the highest level of independence possible, and to achieve his/her goals. The following must be documented on the IICP:

- Outline of goals that the member chose that promote stability and support continued integration into the community, treatment of mental illness symptoms, and habilitation of functional deficits related to the mental illness (including co-occurring SMI and substance use disorders).
- Individuals and/or teams responsible for treatment, coordination of care, linkage, and referrals to internal as well as external resources and care providers to meet identified needs.
- Identifies by title the AMHH service(s) the applicant/member is assessed to need and has indicated as a desired service on the proposed IICP.
- A listing of all other services and supports which will be delivered in conjunction with the proposed AMHH services.

Note: The primary distinction between the AMHH habilitation services and the MRO rehabilitation services will be in the IICP treatment goals. MRO has an expectation that the individual will improve his/her level of functioning over time. The AMHH expectation will be that the IICP goals address reinforcement, management, adaptation and/or retention of a level of functioning.

As a part of the completed IICP, the State also requires documentation, signed by the applicant and provider participating in the development of the IICP, which attests to the following:

- The applicant has been given choice of providers. This applies to choice in both the provider agency and providers within an agency itself.
- Individual has been given choice of services to be provided.
- The proposed IICP is individualized to meet the applicant's needs.
- The applicant has participated in the development of the IICP. Applicant's attestation verifying his/her participation in the development of the IICP and determining which AMHH services will be included on the plan of care.
- Program requirements, including financial requirements, have been reviewed with applicant.
- The services proposed on the IICP are deemed appropriate and medically necessary, as verified by the psychiatrist or HSPP.
- Psychiatrist or Health Services Provider in Psychology (HSPP) attestation regarding the imminent likelihood that without ongoing habilitation services the applicant will likely deteriorate and be at risk of institutionalization (e.g. acute hospitalization, State hospital, nursing home, jail).

- Applicant is not a danger to self or others at the time this application is submitted.

CRISIS PLAN

AMHH members must be deemed stable enough to benefit from intensive home and community-based habilitation services. However, the target population is generally considered to be vulnerable and susceptible to crises. To ensure a member's safety and successful utilization of AMHH services, a crisis plan is an important part of the treatment planning process and a requirement for all members receiving AMHH services. The crisis plan is created based upon consumer-focused triggers and identifies a means to deal with potential crises that put the member at risk of hospitalization or institutionalization if the crisis is not mitigated or averted. The plan puts in place supports that assist the member in avoiding or coping with the identified triggers that typically result in a crisis for the member. The AMHH provider agency, in conjunction with the member, must develop a crisis plan to address any identified potential crises that may interfere with the member's ability to remain in the community. This section provides providers with information and resources to assist the member in developing an individualized crisis plan.

The following is required of the provider agency in the development of the crisis plan:

- The crisis plan must be developed with the member (and family/caregiver, if applicable).
- The plan should reflect the choice and preferences of the member (and family/caregiver, if applicable).
- Submission of the crisis plan document to the SET is optional, but in all cases, the crisis plan must be maintained in the clinical record and made available for review by FSSA/DMHA.

While the format of the crisis plan is at the discretion of the AMHH provider agency to define and implement, the following components must be included as important components in a comprehensive crisis plan:

- Potential crises that are identified and documented during the face-to-face evaluation process and the development of the proposed IICP and per member or family/caregiver reports of past crisis situations, if applicable.
- Indicators of emerging risks, impending crises, and increased levels of risk are identified in the crisis plan.
- Crisis defusing strategies to which the member has responded well in the past are noted, as well as action steps to prevent or mitigate potential identified crises.
- Individuals are identified to provide assistance to the member in completion of the action steps documented on the crisis plan (i.e., family, natural supports, community resources and formal supports; including a back-up and contingency plan if the identified resource or individual cannot be accessed during the crisis).
- Specific AMHH services may be added to the proposed IICP to build coping skills, defuse crises, or provide support during a crisis (e.g., Respite, Peer Support).

An example crisis plan is included in Appendix E of this manual.

MEMBER REFUSAL TO SIGN IICP

The IICP must reflect the applicant/member's desires and choices. The applicant/member's signature, demonstrating his/her participation in the development of initial and ongoing IICP reviews, is required on the proposed IICP submitted to the SET for review and approval. Infrequently, an applicant/member may request services but refuse to sign the IICP for various reasons (i.e. thought disorder, paranoia, etc.). If a member refuses to sign the IICP, the agency staff member is required to document on the plan of care that the member agreed to the plan but refused to sign the plan. The agency staff member must also document in the clinical record progress note that a planning meeting with the member did occur and that the IICP

reflects the member's choice of services and agreement to participate in the services identified in the IICP. The progress note must further explain any known reasons why the member refused to sign the plan and how those will be addressed in the future.

ONGOING IICP REVIEW

The provider agency is responsible to ensure that a member's progress and movement toward attaining the IICP goals is monitored on a regular basis, and that the IICP continues to meet the member's identified strengths, needs, goals and preferences. At minimum, the IICP must be reviewed every 90 days as part of the member's regular 90-day treatment review. If additional AMHH services are warranted, an updated proposed IICP must be submitted to the SET requesting a new service authorization. Delivery of the proposed new AMHH service(s) may not commence until SET approval has been granted. Refer to *Section 11: Request for Approval of Additional AMHH Services* for further information.

SECTION 10: AMHH ELIGIBILITY DETERMINATION, SERVICE APPROVAL AND UTILIZATION

Under the direction and supervision of FSSA (FSSA/DMHA and FSSA/OMPP), the SET is exclusively responsible for the determination of AMHH eligibility and approval of AMHH services on the proposed IICP. This section of the provider manual will describe the SET processes for determining AMHH eligibility and approval of AMHH services.

THE STATE EVALUATION TEAM (SET)

The SET assesses all AMHH applications for program and services eligibility. The team is responsible for determining the following:

- Eligibility for enrollment/re-enrollment in AMHH program.
- Appropriateness of proposed IICP and requested services in meeting the applicant's needs.
- Clinical authorization of approved AMHH services.

AMHH ASSESSMENT AND MEMBER ELIGIBILITY DETERMINATION

The AMHH provider agency submits the AMHH application to the SET for independent review and assessment of the applicant's AMHH eligibility. The SET reviews all applications and approves or denies authorization for the specific AMHH services submitted on the proposed IICP.

Upon receipt of the AMHH application, the SET will engage in the following activities to determine if the applicant meets eligibility for the AMHH services program:

- Review of the AMHH application for completeness.
- Verify the applicant meets all target group and needs-based eligibility criteria for AMHH services (Refer to *Section 5: AMHH Program Member Eligibility* for additional information).
- Ensure the AMHH IICP indicates all of the required attestations.
- Review the proposed IICP to ensure plan meets the following criteria and supports the need for AMHH services:
    - IICP includes the applicant's strengths and needs, as supported by the clinical documentation and ANSA.
    - Goals and objectives are linked to the applicant's identified needs.
    - Strategies support the goals, objectives and needs.
    - Evidence provided that the applicant will benefit from habilitation services.
    - Evidence that the IICP submitted is individualized and driven by the applicant's needs and preferences.
    - AMHH services proposed are supported by the IICP and clinical documentation submitted with the AMHH application.
    - A listing of non-AMHH services and supports that will be used to assist in meeting the applicant's identified needs not met by AMHH services alone.

If an AMHH application is incomplete, unclear, or has conflicting information, the SET may pend the application and require additional information/documentation from the provider agency. The provider agency has seven (7) calendar days from date the application was pended to submit the required information in DARMHA. In the event that the provider agency does not submit the required information/documentation within seven (7) calendar days, the AMHH application is denied.

Following evaluation and review of the application, the SET will make an AMHH eligibility determination. There are three (3) potential eligibility determinations that the SET may make:

- Approval of AMHH program eligibility with full approval of services
- Denial of AMHH program and/or services eligibility
- Approval of AMHH program eligibility with partial approval of services

Note: AMHH services are requested individually, based upon the member's identified need(s) documented on the proposed IICP. In some cases, certain requested services on a single IICP may be approved or denied by the SET, based on the independent evaluation of the applicant's needs and the justification provided for the service requested.

AMHH Eligibility Start Date Determination

The start date for AMHH program and services eligibility is determined by the SET. For approved applicants whose MRO package ends *within* sixty (60) days of the date of SET approval, the AMHH start date is the day following the end date of the current MRO service package. This will ensure there is no lapse in service delivery for the member.

For approved applicants whose MRO package ends *beyond* sixty (60) days from date of the SET approval, the start date is set at fifteen (15) calendar days from the date of SET approval of the AMHH application.

There may be circumstances where an applicant and provider identify a need to initiate AMHH services sooner than the start date normally determined by the SET. These requests will be considered on a case-by-case basis and the start date assigned as needed.

For members already receiving AMHH services, the start date for the new AMHH service package is the day following the end date of the current AMHH service package. This will ensure there is no lapse in service delivery for the member.

Communication of SET Eligibility Determination

Approval or denial of AMHH eligibility or services is communicated to the referring provider agency and/or the applicant or authorized representative in the following manner:

- *Approval of AMHH program eligibility with full approval of services*: If an applicant is determined eligible for the AMHH program and for all services requested on the IICP, an authorization notification is sent to both the referring AMHH provider and the applicant or authorized representative. This authorization notification is generated by HP and includes the following information:
    - Start and end dates for AMHH program eligibility and services.
    - AMHH services approved by the SET, including the procedure code, modifiers and number of units approved.

- *Denial of AMHH program and/or services eligibility:* If an applicant is determined ineligible for the AMHH program, or the SET denies all of the AMHH services requested on the proposed IICP, a denial notification is sent to both the applicant or authorized representative and the referring AMHH provider. This denial notification is generated by the SET and includes the following information:
    - Notification of the reason(s) the SET determined the applicant is not eligible for the AMHH program, and/or
    - Notification of the reason(s) that the specific services requested on the proposed IICP is denied.
    - Information regarding the applicant's fair hearing and appeals rights.
- *Approval of AMHH program eligibility with partial approval of services*: If an applicant is determined eligible for the AMHH program, but one or more (though not all) of the services requested on the proposed IICP are denied, both an authorization notification and a denial notification are generated and sent to both the referring AMHH provider and the applicant or authorized representative. The authorization notification is generated by HP and includes the following information:
    - Start and end dates for AMHH program eligibility and services.
    - AMHH services approved by the SET, including the procedure code, modifiers and number of units approved.

  The denial notification is generated by the SET and includes the following information:
    - Notification of the reason(s) that the specific services requested on the proposed IICP is denied.
    - Listing of the requested services that are approved by the SET.
    - Information regarding the applicant's fair hearing and appeals rights.

The referring AMHH provider agency is responsible for alerting the applicant/member of the SET's eligibility determination and, in the event of a denial notification, assists the member in understanding the reasons for the denial and/or pursuing the fair hearing and appeals process, as applicable.

Information regarding the status of AMHH eligibility determination and approval of AMHH services may be accessed by providers via DARMHA, and authorization of AMHH service units via Web interChange: https://interchange.indianamedicaid.com/Administrative/logon.aspx.

AMHH Services Eligibility Period

The AMHH services eligibility period is one year (360 days) from the start date documented on the AMHH eligibility authorization notification, or as determined by the SET. AMHH service delivery may not begin until the service approval from the SET is authorized, and the AMHH service(s) package is assigned to the member by HP. AMHH provider agencies will not receive reimbursement for any AMHH services provided without SET approval and authorization, or for services provided outside of the AMHH eligibility period as documented on the authorization notification. The provider agency is required to:

- Continually monitor the member's progress in/benefit from AMHH services and notify FSSA/DMHA if there is any change in status that impacts the member's eligibility for AMHH services.
- When the member's needs change requiring a new/different AMHH service(s), the provider must update the IICP and submit it to the SET for review and approval of the requested AMHH service(s) (refer to *Section 11: Request for Approval of Additional AMHH Services* for information regarding a request for additional AMHH services).

- Track the end date of the member's AMHH program and services eligibility and submit an AMHH renewal application at least 30 days (but no more than 60 days) prior to the end date of the existing AMHH eligibility period – see *Section 12* for additional information.

> **Note:** The AMHH provider agency is responsible to ensure the AMHH services renewal application is submitted to the SET at least 30 days prior to the expiration date of the member's AMHH eligibility period. In addition, a new ANSA must be completed and submitted within 60 days of the AMHH renewal application creation.

AMHH Units of Services Approval

The SET authorizes AMHH services for an AMHH-eligible member, based upon review and acceptance of the proposed IICP submitted in DARMHA. The AMHH services approval provides a ***maximum*** number of service units for each AMHH service approved. AMHH providers must coordinate service delivery to ensure the AMHH service units approved by the SET are managed in a way to ensure continued service delivery throughout the AMHH eligibility period based upon the member's needs. No additional units of service can be requested during the authorized eligibility period. However, if the member's needs change, an additional AMHH service (one not already authorized) may be requested. Refer to *Section 11: Request for Approval of Additional AMHH Services* for information regarding a request for additional AMHH services.

Interruption of AMHH Services

When there is an interruption in AMHH services due to the member leaving the community to enter an institutional setting (e.g., incarceration, hospitalization, etc.), AMHH services are not reimbursable or to be billed during the period of service interruption. The AMHH eligibility and authorized service units will remain available to the member, within the originally authorized AMHH eligibility period, for immediate access when the member returns to the community from an institutional setting and chooses to restart AMHH services.

If, however, the member does not return to the community during the AMHH eligibility period, the member must reapply for AMHH services prior to or upon reintegration into the community, with the assistance of an FSSA/DMHA-approved AMHH provider agency. To retain continuity of care, AMHH program eligibility and service requests may be applied for while an individual is in an institutional setting and preparing for a discharge back into the community, so long as a specific discharge date within 90 days of the application submission has been identified. If approved, AMHH services are not reimbursable until the applicant has returned to a community-based setting.

Termination of AMHH Services

In the event there is a need to terminate AMHH services prior to the end of the AMHH eligibility period due to the member no longer meeting AMHH criteria or a member's request to terminate AMHH services, the provider agency must assist in linking the member to services that may be able to meet the individual's needs (Refer to *Section 13: Transition From AMHH Services* for information regarding a transition to MRO services).

If the provider agency's efforts to facilitate a transition in services for the member are not successful, the provider agency must document in the clinical record the attempts made to coordinate transition to other services.

SECTION 11: REQUEST FOR APPROVAL OF ADDITIONAL AMHH SERVICES

In the event that an AMHH member's needs change and additional AMHH services are indicated to meet the needs of the member, the provider agency may request approval of additional AMHH services not already approved by the SET in the member's current AMHH eligibility period. **Additional AMHH service units are not authorized for services already approved within the member's AMHH eligibility period.**

A request for additional AMHH services is initiated when the AMHH provider agency submits a request to the SET, as follows:

- Provider agency completes an updated IICP (with "AMHH Modification" indicated on the application form) and submits it to the SET via DARMHA.
- Upon receipt of the AMHH Modification Application, the SET will review the modified IICP and supporting documentation as described in *Section 10* of this manual.
- After evaluation and review of the modified IICP, the SET will make a determination regarding the request to add new AMHH service(s).

Approval or denial of requested additional AMHH services is communicated to the referring provider agency and the applicant or authorized representative in the following manner:

- *Approval of additional AMHH services*: If the SET approves the requested additional AMHH service(s), an authorization notification is sent to the referring AMHH provider and the member or authorized representative notifying them of the approval determination. The authorization notification is generated by HP and includes the following information:
    - AMHH service(s) approved, including the procedure code, modifiers and number of units approved.
    - Start and End dates for the approved AMHH service(s). When additional services are approved, the Start Date will be the date the SET gives approval for the requested service. The End Date is the same as the member's current AMHH eligibility period end date.

> **Note:** The AMHH provider agency is responsible for alerting the applicant/member of the SET's eligibility determination and, in the event of a denial notification, assists the member in understanding and/or pursuing the fair hearing and appeals process, as applicable.

- *Denial of additional AMHH services:* If the SET denies one or more requested additional AMHH service(s) on the modified IICP, a denial notification is sent to the member and referring AMHH provider notifying them that the AMHH service(s) requested was denied. The denial notification is generated by the SET and includes the reason for denial and information regarding the applicant's fair hearing and appeals rights.

The additional AMHH service(s) authorized are subject to the applicable AMHH service unit limitations for that service, and have an expiration date that matches the member's existing AMHH eligibility period expiration date. Information regarding assignment of additional AMHH service packages may be accessed by providers on Web interChange: https://interchange.indianamedicaid.com/Administrative/logon.aspx.

Service delivery for the requested additional AMHH service(s) may not begin until approval and authorization from the SET is complete and the service(s) is assigned by HP. AMHH provider agencies will not receive reimbursement for any AMHH services provided without SET approval and authorization

or for services provided outside of the AMHH eligibility period documented on the authorization notification.

Example 11.1: Request for Additional AMHH Services

Example: *Request for Additional AMHH Services*

An AMHH member receives an eligibility approval determination for AMHH services on January 1st (for 360 days). In June, the applicant begins to decompensate due to increased alcohol consumption and poor judgment in time utilization during the day when the member's caregiver (roommate) is at work. Additional services are indicated to support the AMHH member in the community. The additional services are requested by the AMHH provider and are approved by the SET on June 20th. The newly approved services have the same expiration date as the AMHH eligibility period and services authorized in January.

AMHH Service Requested	# Units Authorized	Authorization Period (360 days)	Reason for Denial
The initial AMHH eligibility authorization is granted on January 1st with the following services authorized on the IICP:			
HCB Habilitation and Support	2920	Jan 1 – Dec 26	
Therapy and Behavioral Support Services	96 (individual), 126 (group)	Jan 1 – Dec 26	
Medication Training and Support	728	Jan 1 – Dec 26	
Care Coordination	800	Jan 1 – Dec 26	
The AMHH applicant has increased symptoms and decompensated functioning. The provider requests additional services in order to support the member so they may continue to live safely in the community. Authorization of additional AMHH services is granted on June 20th:			
Adult Day Services	2 half-day units/day, 5 days/week	June 20 – Dec 26	
Addiction Counseling	64	June 20 – Dec 26	
Therapy and Behavioral Support Services	0	Request Denied	*Service already authorized within the same eligibility period.

** AMHH services are authorized with a fixed number of units per time period, based on the individual service. No additional units will be authorized for a service after the initial authorization within the same eligibility period. It is the responsibility of the provider to manage the units authorized to ensure the member's needs are met within the AMHH eligibility period.*

SECTION 12: RENEWAL OF AMHH PROGRAM MEMBER ELIGIBILITY

The member's AMHH program and services eligibility period expires one (1) year (360 days) from the date of the AMHH start date, or as otherwise determined by the SET. In order to continue AMHH services, the AMHH member, in conjunction with the AMHH provider agency, must reapply for AMHH program eligibility at least 30 days (and not more than 60 days) prior to the eligibility expiration date in order to prevent a lapse in service delivery for an eligible member.

The AMHH renewal application and evaluation process is the same as the initial AMHH application process outlined in *Sections 7-9* of this manual, and includes the following:

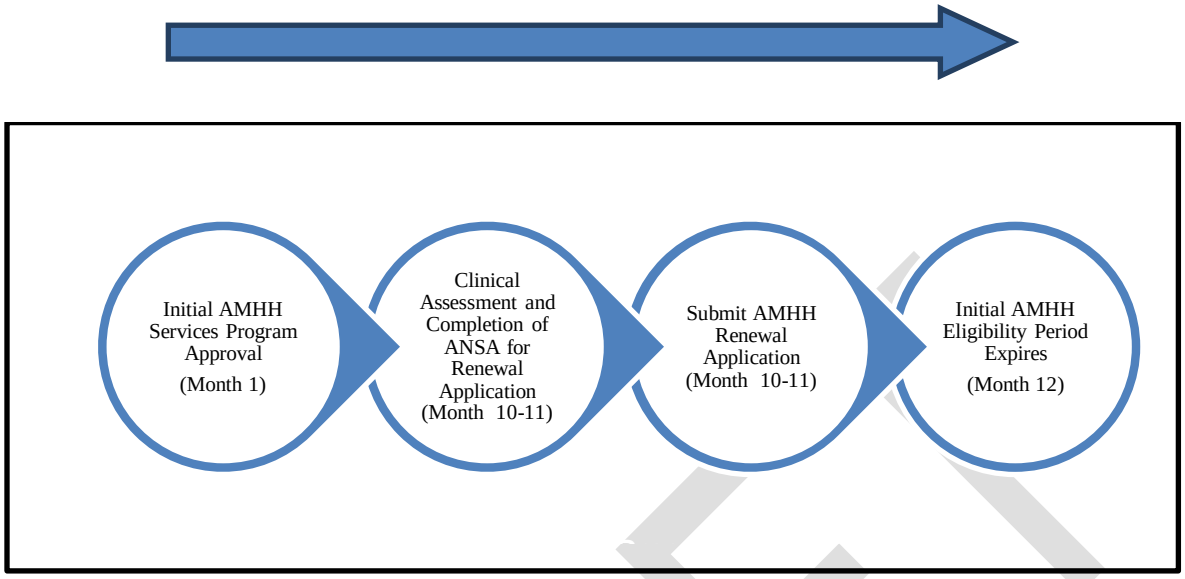
- A face-to-face holistic clinical and biopsychosocial assessment by a qualified FSSA/DMHA-approved AMHH service provider to evaluate the member's strengths, needs and functional impairments.
- Completion of the clinical assessment and ANSA tool, to assess if the member meets the level of need recommendation and needs-based criteria for AMHH services. Completion of the assessment and of the ANSA must be within 60 days of creation of the AMHH renewal application
- Update of the IICP, crisis plan and attestations.
- **Evaluation of the member's progress towards meeting established habilitative treatment goals.**
- **If and how the member is receiving benefits from AMHH services.**
- Submission of the renewal application in DARMHA.

Note: The member, with assistance from the AMHH service provider, must reapply for AMHH services program eligibility at least 30 days (but not more than 60 days) prior to the eligibility expiration date to prevent an interruption in service delivery.

If an AMHH application is incomplete, unclear, or has conflicting information, the SET may pend the application and require additional information/documentation from the provider agency. The provider agency has seven (7) calendar days from the date the application was pended to submit the required information in DARMHA. In the event that the provider agency does not submit the required information/documentation within seven (7) calendar days, the AMHH application is denied.

Approval or denial of continued AMHH eligibility and services is communicated to the referring provider agency and the applicant or authorized representative as described in *Section 10*.

Diagram 12.1: AMHH Services Program Renewal Application Timeline



SECTION 13: TRANSITIONS DURING AMHH ELIGIBILITY PERIOD

The AMHH provider agency must respect the AMHH member's right to freedom of choice regarding program participation and choice of AMHH service providers. The AMHH provider agency must provide assistance to the greatest extent possible to facilitate a transition or change in AMHH service providers at the member's request. It is the responsibility of the AMHH provider agency to coordinate any transition in services for an AMHH member, such as:

- Transition between AMHH provider staff members within the same AMHH provider agency.
- Transition between AMHH provider agencies.
- Transition from AMHH services to other programs such as MRO, as applicable.

TRANSITION BETWEEN AMHH SERVICE PROVIDER STAFF WITHIN AN AGENCY

AMHH members have the right to choose who provides their services within an agency. They may request specific agency staff provide AMHH services, so long as those staff members are appropriately qualified and trained to provide the service. All requests must be honored, whenever possible, to ensure member choice.

TRANSITION BETWEEN AMHH PROVIDER AGENCIES

To assist in a transition between provider agencies, the current AMHH provider agency shall engage in the following to maintain continuity of care for the member:

- Provide the member with a randomized listing of AMHH provider agencies that are within the member's county of residence and contiguous counties, so the member is able to make an informed choice in the selection of a new AMHH provider agency.
- Assist in linking the member with the new AMHH provider agency, which includes the transfer of clinical information to coordinate care (with a signed consent if the transfer is between provider agencies and not an internal transfer within the same agency). The information transferred may include the member's last assessment, current treatment plan and progress notes, crisis plan, etc., that will assist the new provider agency in continuing care with a minimum amount of disruption in service delivery.
- Communicate with the new provider agency regarding service unit utilization during the existing AMHH eligibility period.

Note: Authorization for AMHH services belongs to and follows the AMHH member, not the provider agency. The number of approved AMHH service units will not change due to a transfer between provider agencies. If additional AMHH services are indicated to meet the member's needs (other than the ones originally approved by the SET), the new provider agency must follow the process for requesting additional services. Refer to *Section 11: Approval of Additional AMHH Services.*

VOLUNTARY TRANSITION FROM AMHH SERVICES TO MRO SERVICES

If an AMHH program member chooses, they may request to be transitioned to (or back to) an MRO service package. To assist in a transition to MRO, the AMHH provider agency shall engage in the following to maintain continuity of care for the member:

- Complete and submit an ANSA reassessment within 60 days of the requested date of transition to MRO. A current (within 60 days) ANSA is necessary for determining MRO eligibility and service package assignment.
- Complete and submit a modified AMHH application in DARMHA, including the *Transition to MRO* wizard under the "IICP Form" tab on the application. The requested date of transition must be no earlier than the date of the transition request submission, and no later than the end of the current AMHH eligibility period. Refer to *Section 8: Completing the AMHH Application* for specific instructions.

The SET evaluates the transition request and, when approved, DARMHA sends an AMHH end date to HP. The following day, DARMHA auto-generates an MRO package and sends that to HP for MRO eligibility determination. If the MRO eligiblity criteria and Medicaid status are met (current Level of Need, active Medicaid ID, and diagnosis), HP generates and authorizes an MRO service package with the effective date the day after the AMHH end date. If the date on the most recent ANSA is more than 60 days prior to the AMHH package end date provided by DARMHA, HP will not generate a MRO service package due to date of assessment not qualifying. This may result in a lapse in service authorization for the member. The provider agency will not receive authorization or payment for services delivered between the periods of the AMHH service authorization end and initialization of an MRO service package.

Default Transition From AMHH Services to MRO Services

If the current AMHH eligiblity period ends without an approved AMHH renewal request and the most recent ANSA is less than 60 days old, an MRO file auto-generates from DARMHA. The MRO file is sent to HP for MRO eligibility determination. If the MRO eligiblity criteria and Medicaid status are met (including the Level of Need, active Medicaid ID, and diagnosis), HP generates and authorizes an MRO service package with the effective date the day after the AMHH end date (which will become the AMHH eligibility end date). If the ANSA is more than 60 days old (from AMHH eligibility end date), the provider must complete a new ANSA and submit it to DARMHA to trigger the MRO file being sent to HP for MRO eligibility determination. If neither AMHH nor MRO eligibility is established through this process, it will result in a lapse in program eligiblity and service authorization for the member. The provider agency will not receive payment for services delivered outside of an authorized eligiblity period for either program.

MRO ELIGIBILITY DETERMINATION IS CONTINGENT ON CURRENT ASSESSMENTS. It is strongly encouraged for providers to complete an ANSA reassessment within the required time frame (no more than 60 days prior to the end date of the current service package eligibility end date) to support ongoing or re-establishing program eligiblity. Additional information regarding MRO eligibility and service packages may be referenced in the Medicaid Rehabilitation Option Provider Manual located on the Indiana Medicaid website, www.indianamedicaid.com.

SECTION 14: CLINICAL AND ADMINISTRATIVE DOCUMENTATION

The AMHH provider agency shall maintain compliance with documentation requirements as defined by CMS, FSSA (FSSA/OMPP and AMHH) provider manual and 405 IAC 1-5. All clinical record documentation shall contain information that reflects the AMHH service(s) provided to the member. The documentation required to support billing for AMHH services must include the following:

- Focus on the member.
- Emphasize the member's strengths.
- Reflect member's progress toward the habilitation goals reflected in the IICP.
- Be present in the member's medical record for every member encounter that billing is submitted for reimbursement.
- Be written and signed by the provider rendering services (and cosigned if applicable).
- Follow all documentation requirements outlined in this manual.

Refer to *AMHH Services (Sections 15-23)* in this provider manual for complete service definitions, provider qualifications, program standards and exclusions.

SERVICE LOCATION SPECIFICATIONS

It is essential that the location where an AMHH service is provided must be clearly documented in the member's clinical record. AMHH is a 1915(i) Home and Community-Based Services program, so with few exceptions, AMHH services must be provided in home and community-based settings to be eligible for reimbursement. Additional information can be found in *Section* 6 and *Sections 15-23* of this manual, and on the FSSA Home and Community-Based Services Final Rule website at: http://www.in.gov/fssa/4917.htm

GENERAL DOCUMENTATION REQUIREMENTS

The AMHH provider agency must comply with the standards for documentation required for each AMHH service provided. While each specific AMHH service may have its own unique documentation requirements in addition to the general requirements listed here, this section provides information about general documentation requirements that apply to all AMHH services. Documentation standards specific to each AMHH service are detailed, along with the service definition, scope, limitations and exclusions, in subsequent sections of this manual (Refer to *Sections 15-23*). Providers are responsible for understanding and adhering to the requirements and limitations for each service they are qualified and authorized to provide. Questions about a service and its requirements may be directed to the SET, who is responsible for completing AMHH quality assurance activities in support of CMS and FSSA/OMPP requirements for the delivery of AMHH services. The following applies to each AMHH service that is claimed for reimbursement:

- All AMHH service and eligibility documentation is subject to review by CMS and the State, or their designees.
- The provider is subject to denial of payment or recoupment for paid claims for services if the provider does not have adequate documentation to support the AMHH service billed.

The following documentation requirements apply for each AMHH service encounter:

- Type/title of service being provided.
- Name and qualifications of the staff member providing the service.
- Location or setting where the service was provided.

- Describe focus on member and of the session or service being delivered to or on behalf of the member.
- Symptoms or issues addressed during the session.
- Duration of the service (actual time spent with the member or completing the activity).
- Start and end time of the service.
- Member's IICP goal(s) being addressed during the session.
- Progress made toward the habilitation goals.
- Date of service rendered (including month, day, and year).

Note: Individualized goals are habilitative in nature. Progress may be described as sustained maintenance of skills or functioning, allowing the individual to live in the community in the least restrictive environment possible.

The content of the documentation must support the amount of time billed. In addition to the requirements listed in this section, additional requirements for specific service types are reflected in the following sub-sections.

Services Provided in a Group Setting

For members participating in AMHH services provided in a group setting (i.e., Adult Day Services; can also apply to Home and Community-Based Habilitation and Support, Therapy and Behavioral Support, Addiction Counseling, and Medication Training and Support), documentation provided for each encounter must include:

- All items described under General Documentation Requirements subsection.
- Focus or topic of the group or session and how it applied to the specific member's goals.
- Member's level of engagement and participation in the group session. Simply noting whether or not the member was present in the group does not constitute adequate documentation.

Services Provided Without the Member Present

For services provided without the member present (can apply to Home and Community-Based Habilitation and Support, Therapy and Behavioral Support, Addiction Counseling, Care Coordination, and Medication Training and Support), documentation provided for each encounter must include:

- All items described under General Documentation Requirements subsection.
- The person(s) who attended the session and their relationship with the member.
- How the session addresses the goals of the specific member.

Service-Specific Documentation Requirements

The following services have additional documentation requirements as described in the following subsections. For all other AMHH services, only the general documentation requirements apply.

Adult Day Services

Adult Day Services is a time-limited, nonresidential service provided in a clinically supervised setting for members who require structured habilitative services to maintain the member on an outpatient basis. Adult Day Services is curriculum-based and designed to alleviate emotional or behavior problems with the goal of transitioning to a less restrictive level of care, reintegrating the member into the community, and increasing social connectedness beyond a clinical setting and/or employment. For a complete definition of this service, see *Section 15* of this manual.

Documentation requirements include, at minimum, a weekly review with details of daily activities and update of progress providing details of services provided each day per the following:

- All items under General Documentation Requirements.
- All requirements noted in the Group Setting Documentation Requirements sections.
- Member's goals and a transitional plan to reintegrate the member into the community.

> **Note:** Providers may opt to use daily documentation versus a weekly review summary as long as there is consistency across the agency in which method is used. A daily review note requires all the same documentation elements noted for weekly review.

RESPITE CARE SERVICES

Services provided to members who are unable to care for themselves. These services are furnished on a short-term basis because of the nonprofessional care giver's absence or need for relief. For a complete definition of this service, see *Section 17* of this manual. Documentation requirements include:

- All items under General Documentation Requirements.
- Primary location of services rendered and the reason for the respite service.
- Nature of the services delivered to the member.
- Documentation of the activities that the member engaged in during the respite and how the member responded.

SECTION 15: ADULT DAY SERVICES

AMHH adult day services consists of community-based group programs designed to meet the needs of adults with significant behavioral health impairments, as identified in the member's IICP. These comprehensive, non-residential programs provide health, wellness, social, and therapeutic activities in a structured, supportive environment. The services provide supervision, support services, and personal care as required by the IICP. AMHH adult day services may include:

- care planning
- behavioral health treatment
- monitoring of weight, blood glucose level, and blood pressure
- medication administration
- nutritional assessment and planning
- individual or group exercise training
- training in activities of daily living
- skill reinforcement on established skills

Adult day service may also include other social activities as indicated to meet identified needs and goals established in the IICP

PROVIDER QUALIFICATIONS

Provider staff of AMHH adult day services must meet the following standards:

- A licensed professional, except for a licensed clinical addiction counselor
- A Qualified Behavioral Health Professional (QBHP)
- An Other Behavioral Health Professional (OBHP)
- Medication administration provided as an AMHH adult day service activity must be delivered by a provider who meets one of the following qualifications:
  - A licensed physician
  - An authorized health care professional (AHCP)
  - A registered nurse (RN)
  - A licensed practical nurse (LPN)
  - A medical assistant (MA) who has graduated from a two year clinical program
- Nutritional assessment and planning services provided as an AMHH adult day service activity must be provided by a certified dietician as defined in IC 25-14.5-1-4.

Refer to the Agency Staff Requirements subsection in *Section 3: AMHH Service Providers* for additional information on staff member qualifications.

PROGRAMMING STANDARDS

Programming standards for AMHH adult day services include the following:

- The service requires face-to-face contact with the member in which the member must be the focus of the service delivered.
- Member goals must be designed to facilitate community integration and use of natural supports.
- Therapeutic services include clinical therapies, psychoeducational groups, and habilitative activities.
- Documentation must support how the service benefits the specific member, including when the service is provided in a group setting.

- Medication administration must be provided within the scope of practice of the provider staff member, as defined by federal and State law. Refer to the *Indiana Professional Licensing Agency* for additional information.
- Nutritional assessment and planning services must be delivered by a certified dietician and provided within the scope of practice, as defined in state and federal law. Refer to the *Indiana Professional Licensing Agency* for additional information.
- Each day of service must be appropriately documented in the member's clinical record.
- At a minimum, a weekly review and update of the member's progress toward habilitative goals will occur and be documented in the member's clinical record. Providers may opt to use daily documentation versus a weekly review summary as long as there is consistency across the agency in which method is used. A daily review note requires all the same documentation elements noted for weekly review.

Clinical Oversight Requirement

Program standards for AMHH adult day services require that clinical oversight of the program must be provided by a licensed physician. This licensed physician must be on-site at least once a week, and available to program staff when not physically present on-site. This is in addition to the general requirement that approved agency staff (QBHP, OBHP, etc.) must be supervised by a licensed professional.

Exclusions

General AMHH program exclusions are outlined in the *Non-Covered Services* subsection in *Section 2: AMHH Services.* The following specific exclusions apply, and are non-reimbursable/non-covered, for AMHH adult day services:

- Formal educational or vocational services are considered non-reimbursable/non-covered.
- Adult Day Services are not eligible for reimbursement if provided in a residential setting, as defined by FSSA/DMHA.
- Any service provided simultaneously with another service (only one of the services provided is billable).

HCPCS

Service Table 15.1 – HCPCS Codes for Adult Day Services

Code	Modifier(s)	Code Description
S5101	UB	Adult Day Services; half-day (1/2 day) unit

SERVICE UNIT DESCRIPTION AND LIMITATIONS

The basic unit of service for AMHH adult day services is a half-day (1/2 day) unit. A single half-day unit is defined as the provision of service for a minimum of three (3) hours to a maximum of five (5) hours/day.

- Two units are defined as the service provided for more than five (5) hours to a maximum of eight (8) hours/day.
- A maximum of two half-day (1/2 day) units/day is allowed, up to 5 days per week, with a maximum of 10 units in a 5-day period. A second half-day unit may only be billed when a previous entire half-day unit (5 hours, plus 60-minute break) has been provided to the member.

See *Section 24: AMHH Services Program Billing* for additional guidance about calculating and billing service time for Adult Day Services.

SECTION 16: HOME AND COMMUNITY-BASED HABILITATION AND SUPPORT SERVICES

AMHH home and community-based habilitation and support services are individualized face-to-face services directed at the health, safety and welfare of the member and intended to:

- provide skills training to reinforce established skills (may include activities of daily living)
- assist in the management, adaptation and/or retention of skills necessary to support the individual's ability to live successfully in the most community integrated setting appropriate to his or her needs
- assist the member in gaining an understanding of the self-management of behavioral and medical health conditions.

Skills training, as used in this service description, means assisting in the reinforcement, management, adaptation and/or retention of skills necessary to live successfully in the community. Services are provided in the member's home (living environment) or other community-based settings outside of a clinic or office environment.

Home and community-based habilitation and support services may be provided in a variety of settings:

- to the member individually in either an individual setting or a group setting
- to family members or other nonprofessional caregivers, in an individual or group setting, **with or without** the member present.

An *individual setting* means that the activity is meant to benefit one consumer, and may include family members and/or nonprofessional caregivers, whether or not the consumer is present during the activity. A g*roup setting* means that the activity is meant to benefit more than one consumer, and may include family members and/or nonprofessional caregivers of multiple consumers, whether or not the consumers are present during the activity. The benefit to the consumer must be in accordance with each consumer's individual treatment goals.

Example 1: An AMHH consumer "John" attends a family counseling session with his siblings and mother. Since the session is intended to benefit only John, it is considered an individual setting, even though multiple people are present.

Example 2: The families of several consumers meet for an orientation session to an upcoming AMHH skills development group, which will be attended by several AMHH consumers. Since the group will include more than one consumer, it is considered a group setting.

PROVIDER QUALIFICATIONS

Provider staff of AMHH home and community-based habilitation and support services must meet one of the following:

- A licensed professional, except for a licensed clinical addiction counselor
- A Qualified Behavioral Health Professional (QBHP)
- An Other Behavioral Health Professional (OBHP)

Refer to the Agency Staff Requirements subsection in *Section 3: AMHH Service Providers* for additional information on staff member qualifications.

PROGRAMMING STANDARDS

Programming standards for AMHH home and community-based habilitation and support services provided include:

- Face-to-face contact with the member, and/or with or without their family member(s) and/or nonprofessional caregiver(s) present, in an individual or group setting.
- The member is expected to show benefit from the services.
- Services must be goal-oriented and related to the IICP.
- Where provided to family members or caregivers, services must be focused on the member and improve the ability of the parent, family member, or primary caregiver to provide care to or for the member.
- Activities include:
    - implementation of the IICP
    - assistance with personal care
    - coordination and facilitation of medical and nonmedical services to meet healthcare needs
    - **When family members and/or nonprofessional caregivers are present,** training and education to instruct a parent, or other family member(s) identified in the IICP, or a primary (nonprofessional) caregiver about the treatment regimens appropriate to the member may be provided.
- Services may include, but are not limited to, the following:
    - Skills training in food planning and preparation, money management, and maintenance of the living environment.
    - Medication-related education and training by nonmedical staff.
    - Training in appropriate use of community based activities such as riding the bus, going to the library, participating in natual support systems such as faith based or social activities in the community.
    - Training in skills needed to locate and maintain a home, including:
        - Landlord/tenant negotiations.
        - Budgeting to meet housing and housing-related expenses.
        - Locating and interviewing prospective roommates.
        - Renter's rights and responsibilities.

> Activities allowed under HCB Habilitation and Support are intended to focus on the maintenance of basic skills to live in the community.
>
> Activities allowed under Supported Community Engagement are intended to engage a member in meaningful community involvement through activities such as volunteerism or community service.

EXCLUSIONS

General AMHH program exclusions are outlined in the *Non-Covered Services* subsection in *Section 2: AMHH Services.* The following specific exclusions apply, and are non-reimbursable/non-covered, for AMHH home and community based habilitation and support services:

- Job coaching
- Academic tutoring.
- Services provided to professional caregivers.

- Skill building activities not identified in the IICP.
- Activities billed under HCBS Supported Community Engagement such as skills training and support related to community engagements such as obtaining or maintaining a meaningful purpose or role in the community.

HCPCS

Service Table 16.1 – HCPCS Codes for Home and Community-Based Habilitation and Support Services

Code	Modifier(s)	Code Description
H2014	UB	Home and Community-based Habilitation and Support Services-Individual Setting; 15 minute unit
H2014	UB; HR	Home and Community-based Habilitation and Support Services-Family/Couple with the Member Present (Individual Setting); 15 minute unit
H2014	UB; HS	Home and Community-based Habilitation and Support Services-Family/Couple without Member Present (Individual Setting); 15 minute unit
H2014	UB; U1	Home and Community-based Habilitation and Support Services-(Group Setting); 15 minute unit
H2014	UB; U1; HR	Home and Community-based Habilitation and Support Services-Family/Couple with Member Present (Group Setting); 15 minute unit
H2014	UB; U1; HS	Home and Community-based Habilitation and Support Services-Family/Couple without Member Present (Group Setting); 15 minute unit

Service Unit Description and Limitations

The basic unit of service for AMHH home and community-based habilitation and support services is a 15-minute unit. Home and community-based habilitation and support, including all sub-types (individual or group setting, with or without family/couple or nonprofessional caregivers, with and without member present), may be provided for up to a total of two (2) hours or eight (8) units per day, each day, throughout the eligibility period. See *Section 24: AMHH Services Program Billing* for additional information.

SECTION 17: RESPITE CARE SERVICES

AMHH respite care services are provided to members who are unable to care for themselves, and who are living with a nonprofessional caregiver. The service is provided on a short-term basis because of the nonprofessional caregiver's absence or need for relief. This service is intended to provide support, supervision, and services necessary to ensure the member's health and safety that they are not able to provider for themselves while their primary caregiver is unavailable for a short and defined period of time.

AMHH respite care services may be provided in any of the following locations:

- Member's home or place of residence.
- Caregiver's home.
- Non-private residential setting (such as a group home or adult foster care).

PROVIDER QUALIFICATIONS

Providers of AMHH respite care services, except for medication administration and medical support services provided as a part of respite care, must meet one of the following qualifications:

- A licensed professional, except for a licensed clinical addiction counselor
- A Qualified Behavioral Health Professional (QBHP)
- An Other Behavioral Health Professional (OBHP)

Medication administration and medical support services provided within the AMHH respite care service must be provided within the scope of practice, as defined by federal and state law, by an agency staff member who meets one (1) of the following qualifications:

- A licensed physician
- An advanced practice nurse (APN)
- A physician assistant (PA)
- A registered nurse (RN)
- A licensed practical nurse (LPN)

Refer to *Section 3: AMHH Service Providers* for additional information on provider agency and staff member qualifications.

PROGRAMMING STANDARDS

Programming standards for AMHH respite care services include the following:

- Member must be living with a nonprofessional (unpaid) caregiver.
- Location of service provision and level of professional care is based on the needs of the member receiving the service, including the regular monitoring of medications or behavioral symptoms as identified in the IICP.
- Service must be provided in the least restrictive environment available and ensure the health and welfare of the member.
- Service shall not be used as a substitute for regular care to allow the member's caregiver to:
    - attend school
    - hold a job
    - engage in employment or employment search related activities.
- Medication administration and medical support services provided within respite care must be provided within the scope of practice as defined by federal and state law.
- Services must be provided by a FSSA/DMHA-approved provider.

- Respite care must not duplicate any other service being provided under the member's IICP.

EXCLUSIONS

General AMHH program exclusions are outlined in the *Non-Covered Services* subsection in *Section 2: AMHH Services.* The following specific exclusions apply, and are non-reimbursable/non-covered, for AMHH respite care service:

- Services provided to a member living in a FSSA/DMHA-certified residential facility.
- Services provided to a member living in supportive housing.
- Services provided to a member who receives in-home support from a professional caregiver, rather than a nonpaid caregiver.
- Services provided to the member by family or friends (respite services must be provided by a FSSA/DMHA-approved provider).
- Any service that meets the definition of hospice services.
- Respite care provided by either of the following:
    - any relative who is the primary caregiver of the member
    - anyone living in the member's residence.

HCPCS

Service Table 17.1 – HCPCS Codes for Respite Care Services

Code	Modifiers	Code Description
S5150	UB	Hourly Respite Care Services, for billing up to 7 hours in the same day; 1 Unit = 15 minutes
S5151	UB	Daily Respite Care Services, for billing 8 – 24 hours in the same day; 1 Unit = 1 day

SERVICE UNIT DESCRIPTION AND LIMITATIONS

There are two basic units of service for AMHH respite care services. This service may be billed as *hourly* or *daily*. The available number of units per AMHH eligibility period depends on whether it is provided either hourly or daily, as described below:

- *Hourly Respite Care*: the basic unit is a 15-minute unit, which applies to services provided up to seven (7) hours or 28 units per day. Hourly Respite Care is available for a maximum of seventy-five (75) hours (300 units) per the member's AMHH eligibility period.
- *Daily Respite Care*: the basic unit is a single-day unit, which applies to services provided between eight (8) and twenty-four (24) hours **within the same calendar day**. Daily Respite Care may be provided for up to fourteen (14) consecutive days for a maximum of twenty-eight (28) days per eligibility period.

Hourly and Daily Respite Care may not be billed on the same calendar day.

SECTION 18: THERAPY AND BEHAVIORAL SUPPORT SERVICES

AMHH therapy and behavioral support services consist of a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the IICP. Services must be provided at the member's home (living environment) or at a location outside of the clinic setting.

AMHH therapy and behavioral support services may be provided in a variety of settings:

- to the member individually in either an individual setting or a group setting, or
- to family members or other nonprofessional caregivers, in an individual or group setting, **with or without** the member present.

Refer to *Appendix A* for the definitions of individual and group settings as they apply to this service.

PROVIDER QUALIFICATIONS

Providers of therapy or behavioral support services must meet one of the following qualifications:

- A licensed professional, except for a licensed clinical addiction counselor
- A qualified behavioral health professional (QBHP)

Refer to *Section 3: AMHH Service Providers* for additional information on provider agency and staff member qualifications.

PROGRAMMING STANDARDS

Programming standards for AMHH therapy and behavioral support services include the following:

- Services must be provided face-to-face with the member and/or their family members or nonprofessional caregivers.
- The member must be the focus of the treatment, and documentation must support how the service specifically benefits the member.
- Services must address one or more goals identified in the IICP, and these goal(s) must be habilitative in nature.
- Documentation must demonstrate progress toward and/or achievement of individual treatment goals.
- Therapy and behavioral support services include, but are not limited to, the following:
    - Observation of the member and environment for purposes of the development of the IICP.
    - Development of a person-centered behavioral support plan and subsequent revisions which may be a part of the IICP.
    - Implementation of the behavior support plan for staff, family members, roommates, and other appropriate individuals
    - Assertiveness and/or relationship building
    - Addressing and managing behavioral health symptoms and/or impairment
    - Stress reduction techniques
    - Development and retention of socially accepted behaviors

EXCLUSIONS

General AMHH program exclusions are outlined in the *Non-Covered Services* subsection in *Section 2: AMHH Services*. The following specific exclusions apply, and are non-reimbursable/non-covered, for AMHH therapy and behavioral support services:

- Service provided in a clinic setting is not billable as an AMHH service (but may qualify for reimbursement under the Medicaid Clinic Option).

HCPCS

Service Table 18.1 – HCPCS Codes for Therapy and Behavioral Support Services

Code	Modifiers	Code Description
H0004	UB	Therapy and Behavioral Support Services – Individual Setting; 1 Unit = 15 minutes
H0004	UB; HR	Therapy and Behavioral Support Services – Family/Couple with Member Present (Individual Setting); 1 Unit = 15 minutes
H0004	UB; HS	Therapy and Behavioral Support Services – Family/Couple without Member Present (Individual Setting); 1 Unit = 15 minutes
H0004	UB; U1	Therapy and Behavioral Support Services – Group Setting; 1 Unit = 15 minutes
H0004	UB; U1; HR	Therapy and Behavioral Support Services – Family/Couple with Member Present (Group Setting); 1 Unit = 15 minutes
H0004	UB; U1; HS	Therapy and Behavioral Support Services – Family/Couple without Member Present (Group Setting); 1 Unit = 15 minutes

Service Unit Description and Limitations

The basic unit of service for AMHH therapy and behavioral support services is a 15-minute unit. The available number of units per AMHH eligibility period is determined according to the setting (individual or group) in which the service was provided:

When provided in an individual setting, including a combination of all three (3) subtypes (member only, family/couple or caregivers with and without the member present), the service may be provided for a maximum of twenty-four (24) hours (96 units) per year.

When provided in a group setting, including combination of all three (3) subtypes (multiple members, family/couple or caregivers with and without the member present), the service may be provided for a maximum of thirty (30) hours (120 units) per year.

SECTION 19: ADDICTION COUNSELING SERVICES

AMHH addiction counseling services consist of a series of planned and organized face-to-face services where addiction professionals and other clinicians provide counseling interventions that work toward the member's recovery goals identified in the IICP, as they pertain to substance-related disorders. Services must be provided at the member's home (living environment) or at other locations outside the clinic setting. Services under this section may be provided for members with a substance-related disorder with any of the following:

- Minimal or manageable medical conditions.
- Minimal withdrawal risk.
- Emotional, behavioral, and cognitive conditions that will not prevent the member from benefitting from this service.

> The provider must ensure that a substance use diagnosis is reflected in the applicant's DARMHA record, when requesting Addiction Counseling Services.

AMHH addiction counseling services may be provided in a variety of settings:

- to the member individually in either an individual setting or a group setting, or
- to family members or other nonprofessional caregivers, in an individual or group setting, **with or without** the member present.

Refer to *Appendix A* for the definitions of individual and group settings as they apply to this service.

PROVIDER QUALIFICATIONS

AMHH addiction counseling services must be provided by qualified addiction professionals or other clinicians that meet either of the following:

- A licensed professional, including a Licensed Clinical Addiction Counselor (LCAC)
- A Qualified Behavioral Health Professional (QBHP)

Refer to *Section 3: AMHH Service Providers* for additional information on provider agency and staff member qualifications.

PROGRAMMING STANDARDS

Programming standards for AMHH addiction counseling services include:

- Face-to-face interaction with the member, family members or nonprofessional caregivers supporting the member.
- The member must always be the focus of addiction counseling.
- Addiction counseling must consist of regularly scheduled sessions.
- Documentation must support how addiction counseling benefits the member, and must demonstrate progress towards and/or achievement of goals identified in the IICP.
- Addiction counseling services may include the following activities:
    - Education on addiction disorders (combined with other addiction treatment service activities).
    - Skills training in:
        - communication
        - anger management

        - stress management
    - Relapse prevention
    - Referral to community recovery support programs, as available.

EXCLUSIONS

General AMHH program exclusions are outlined in the *Non-Covered Services* subsection in *Section 2: AMHH Services*. The following specific exclusions apply, and are non-reimbursable/non-covered, for AMHH addiction counseling services:

- Services provided to a member with withdrawal risk or symptoms.
- Services provided to a member whose needs cannot be managed safely with AMHH services.
- Services provided to a member who requires detoxification services.
- Services provided to a member who is determined to be at imminent risk of harm to the self or to others.
- Addiction counseling sessions that consist only of education services.
- Services provided to professional caregivers.

HCPCS

Service Table 19.1 – HCPCS Codes for Addiction Counseling Services

Code	Modifiers	Code Description
H2035	UB	Addiction Counseling – Individual Setting; 1 Unit = 1 hour
H2035	UB; HR	Addiction Counseling – Family/Couple with Member Present (Individual Setting); 1 Unit = 1 hour
H2035	UB; HS	Addiction Counseling – Family/Couple without Member Present (Individual Setting); 1 Unit = 1 hour
H2035	UB; U1	Addiction Counseling – Group Setting; 1 Unit = 1 hour
H2035	UB; U1; HR	Addiction Counseling – Family/Couple with Member Present (Group Setting); 1 Unit = 1 hour
H2035	UB; U1; HS	Addiction Counseling – Family/Couple without Member Present (Group Setting); 1 Unit = 1 hour

SERVICE UNIT DESCRIPTION AND LIMITATIONS

The basic unit of service for AMHH addiction counseling services is a 1-hour unit. Addiction counseling services, including all subtypes (individual or group setting, family/couple, with and without member present) may be provided for a maximum of sixty-four (64) hours (64 units) per year.

SECTION 20: PEER SUPPORT SERVICES

AMHH peer support service is a face-to-face individual service, typically provided by a certified recovery specialist (CRS) consisting of structured, scheduled activities promoting the following:

- Socialization
- Habilitation
- Recovery
- Self-advocacy
- Development of natural supports
- Maintenance or acquisition of community living skills

PROVIDER QUALIFICATIONS

Staff providers of peer support services must meet both of the following qualifications:

- Meet the FSSA/DMHA training and competency standards for a certified recovery specialist (CRS).
- Be an individual under the supervision of a licensed professional or a qualified behavioral health profession (QBHP).

Refer to *Section 3: AMHH Service Providers* for additional information on provider agency and staff member qualifications.

PROGRAMMING STANDARDS

AMHH peer support services programming standards include:

- Service must be provided face-to-face with the member in an individual setting only.
- Service must be a structured and scheduled activity.
- Service must assist member in obtaining a specific treatment goal in the IICP (i.e., the IICP must contain a specific goal/objective to be directly addressed by peer support services).
- Documentation must support how the service specifically benefits the member.
- Service includes, at a minimum, one (1) or more of the following components:
  - Assisting the member with developing a self-care plan (which may be included in the IICP) and other formal mentoring activities aimed at increasing the active participation of the member in person-centered planning and delivery of individualized services.
  - Assisting the member with the development of psychiatric advanced directives.
  - Supporting the member in problem-solving related to reintegration into the community.
  - Providing education to the member and promoting habilitation, the recovery process, and anti-stigma activities.

EXCLUSIONS

General AMHH program exclusions are outlined in the *Non-Covered Services* subsection in *Section 2: AMHH Services.* The following specific exclusions apply, and are non-reimbursable/non-covered, for AMHH peer support services:

- Services that are purely recreational or diversionary in nature and do not support community integration goals.
- Services provided in a group setting.
- Activities billed under AMHH home and community based habilitation and support services or AMHH care coordination services.

HCPCS

Service Table 20.1 – HCPCS Codes for Peer Support Services

Codes	Modifiers	Code Description
H0038	UB	Peer Support Services; 1 Unit = 15 minutes

SERVICE UNIT DESCRIPTION AND LIMITATIONS

The basic unit of service for AMHH peer support services is a 15-minute unit. Peer support services may be provided for a maximum of 130 hours (520 units) per AMHH eligibility period.

SECTION 21: SUPPORTED COMMUNITY ENGAGEMENT SERVICES

AMHH supported community engagement services are face-to-face activities, delivered on an individual basis and in a community setting. This service is designed to engage a member in meaningful community involvement activities such as volunteerism or community service. Services are habilitative in nature, and are aimed at developing skills and opportunities that lead to improved integration of the member into the community through increasing community engagement. AMHH supported community services may not, however, include explicit employment objectives.

PROVIDER QUALIFICATIONS

Staff providers of supported community engagement services must meet one (1) of the following qualifications:

- A licensed professional
- A qualified behavioral health professional (QBHP)
- An Other behavioral health professional (OBHP)

Refer to *Section 3: AMHH Service Providers* for additional information on provider agency and staff member qualifications.

PROGRAMMING STANDARDS

Programming standards for AMHH supported community engagement services include the following:

- Service requires face-to-face contact with the member in a community setting.
- Service is provided to members who may benefit from community engagement and are unlikely to achieve this level of community integration without the provision of support.
- Service includes assisting the member in developing a relationship with community organizations specific to that individual's interests and needs.
- Involves collaboration with a community organization to develop an individualized plan that identifies specific supports required, organizational expectations, training strategies, time frames and responsibilities.
- Allowable activities are geared for the purpose of achieving a generalized skill or behavior that may prepare the member for an community engagement setting, and may include (but is not limited to) teaching concepts such as:
    - Attendance
    - Task completion
    - Problem solving
    - Safety
- Services must be explicitly identified in the IICP and related to goals identified by the member and may include activities such as:
    - How to use public transportation to get to and from the designated community setting
    - Work environment/modification analysis
    - Work-task analysis (activity intended to enhance the member's functioning in a volunteer (community) setting and not an employment-related goal).
    - Use of assistive technology device/adaptive equipment

Activities allowed under Supported Community Engagement are intended to engage a member in meaningful community involvement through activities such as volunteerism or community service.

Activities allowed under HCB Habilitation and Support are intended to focus on the maintenance of basic skills to live in the community.

EXCLUSIONS

General AMHH program exclusions are outlined in the *Non-Covered Services* subsection in *Section 2: AMHH Services.* The following specific exclusions apply, and are non-reimbursable/non-covered, for AMHH supported community engagement services:

- Reimbursement or compensation paid by the provider agency to the member for performing activities covered under the service. If a provider chooses to compensate a member for job-related activities, the provider must use non-Medicaid funding and must be able to document the funding source.
- Training in specific job tasks.
- Services provided to members who are currently competitively employed.
- Any service that is available as vocational rehabilitation services funded under the Rehabilitation Act of 1973.
- Services provided in a group setting
- Services that include explicit employment objectives.

HCPCS

Service Table 21.1 – HCPCS Codes for Supported Community Engagement Services

Code	Modifiers	Code Description
97537	UB	Supported Community Engagement Services; 1 Unit = 15 minutes

SERVICE UNIT DESCRIPTION AND LIMITATIONS

The basic unit of service for AMHH supported community engagement services is a 15-minute unit. Supported community engagement services may be provided up to a maximum of eighteen (18) hours (72 units) per month.

SECTION 22: CARE COORDINATION SERVICES

AMHH care coordination services consist of activities that assist a member in gaining access to needed medical, social, educational, and other services. These include: direct assistance in gaining access to services, coordination of care, oversight of the member's care in the AMHH program, and linkage to appropriate services.

AMHH care coordination includes the following activities:

- *Assessment to determine service needs*: Includes identifying the member's needs for any medical, educational, social, or other services. Specific assessment activities necessary to form a complete needs assessment of the member may include the following:
  - Documenting the member's history.
  - Identifying needs of the individual.
  - Completing the related documentation.
  - Gathering information from other sources, such as family members and medical providers.
- *Development of the IICP*: Includes the development of a written IICP based upon the information collected through the needs assessment phase. The IICP identifies the habilitative activities and assistance needed to accomplish the member's identified goals and objectives.
- *Referral and Linkage*: Includes activities that help link the member with programs and services that are capable of providing needed habilitative services that meet the member's needs, including but not limited to:
  - Medical providers
  - Social service providers, and
  - Educational providers
- *Monitoring and Follow-up*: Includes contacts and related activities necessary to ensure the IICP is effectively implemented and adequately addresses the needs of the member. Such activities and contacts may include the following:
  - The member
  - Family members or individuals who have a significant relationship with the member being served
  - Non-professional caregivers
  - Providers
  - Other entities
- *Evaluation*: Includes face-to-face contact with the member at least every ninety (90) days for the following reasons:
  - To determine if services are being furnished in accordance with the IICP
  - To assess the adequacy of the services in the IICP
  - To assess any changes in the needs or status of the member
  - To make changes or adjustments to the IICP in order to meet the member's ongoing needs.
  - To evaluate or reevaluate the member's progress toward achieving the IICP's objectives.

Time devoted to formal supervision of the case between the care coordinator and a licensed supervisor to review the member's care and treatment is considered an included care coordination activity. The supervision must be documented appropriately and billed under one provider only.

Provider staff delivering AMHH care coordination services must meet one (1) of the following qualifications:

- A licensed professional
- A Qualified Behavioral Health Professional (QBHP)
- An Other Behavioral Health Professional (OBHP)

Refer to *Section 3: AMHH Service Providers* for additional information on provider agency and staff member qualifications.

PROGRAMMING STANDARDS

Programming standards for AMHH care coordination services include the following:

- Care coordination includes:
    - Development of the IICP
    - Limited referrals to services
    - Activities or contacts necessary to ensure that the IICP is effectively implemented and adequately addresses the mental health or addiction needs, or both, of the member.
- Care coordination does not include direct delivery of medical, clinical or other direct services. It is provided on behalf of the member, not to the member.
- Care coordination must provide direct assistance to the member in gaining access to necessary medical, social, educational, and other services.
- Care coordinator must reevaluate member's progress with a face-to- face contact with the member at least every ninety (90) days for the following reasons:
    - Ensure the IICP is effectively implemented and adequately addresses the needs of the member.
    - Determine if the services are consistent with the IICP.
    - Make changes or adjustments to the IICP in order to meet the member's ongoing needs.
    - Evaluate or reevaluate the member's progress toward achieving the IICP's objectives.

EXCLUSIONS

General AMHH program exclusions are outlined in the *Non-Covered Services* subsection in *Section 2: AMHH Services.* The following specific exclusions apply, and are non-reimbursable/non-covered, for AMHH care coordination services:

- Activities billed under Behavioral Health Level of Need Redetermination (by a non-physician)
- Services provided in a group setting
- Direct delivery of medical, clinical, or other direct services, including but not limited to the following:
    - Training in daily living skills.
    - Training in work skills and/or social skills.
    - Grooming and other personal services.
    - Training in housekeeping, laundry or cooking.
    - Transportation services.
    - Individual, group, or family therapy services.
    - Crisis intervention services.
    - Services that go beyond assisting the member in gaining access to needed services, including but not limited to the following:
        - Paying bills and/or balancing the member's checkbook.
        - Traveling to and from appointments with members.

HCPCS

Service Table 22.1 – HCPCS Codes for Care Coordination Services

Code	Modifiers	Code Description
T1016	UB	Care Coordination Services; 1 Unit = 15 minutes

SERVICE UNIT DESCRIPTION AND LIMITATIONS

The basic unit of service for AMHH care coordination services is a 15-minute unit. Care coordination services may be provided for a maximum of 200 hours (800 units) per eligibility period.

Some members who receive AMHH care coordination services will also be enrolled in the Behavioral and Primary Healthcare Coordination (BPHC) program. This program provides specialized case management to assist in the coordination, referral, and linkage needs of a member with co-occurring mental and physical health concerns. For those members approved for both AMHH and BPHC, the number of AMHH care coordination service units, or BPHC service units, will be adjusted as follows:

- For individuals who have an active AMHH service package assignment at the time of BPHC application, the number of BPHC units will be authorized based on the time left until the AMHH evaluation is due as outlined in the table below. If the AMHH end date is in less than six (6) months, the BPHC end date is aligned with the AMHH end date. If the AMHH end date is more than six (6) months away, the BPHC service will be authorized for a six (6) month period. In both scenarios, the active AMHH authorization period will remain unchanged.

Table 22.2: BPHC Units Authorized with Active AMHH

# Months Until AMHH Expires	# Units of BPHC Authorized
6-12	48
5	40
4	32
3	24
2	16
1	8

- If an individual applies for AMHH after they already have an active BPHC service package assignment, the number of authorized AMHH Care Coordination units (T1016 UB) will be reduced to account for the BPHC service package assignment. The AMHH approval end date will be aligned with the existing BPHC approval period.

SECTION 23: MEDICATION TRAINING AND SUPPORT SERVICES

AMHH medication training and support services involve face-to-face services provided to the member, in an individual or group setting, for the purpose of:

- Monitoring medication compliance.
- Providing education and training about medications.
- Monitoring medication side effects.
- Providing other nursing or medical assessments.

AMHH medication training and support services may also include the training of family members and nonprofessional caregivers to assist with the member's medication management needs. When provided to family members or other nonprofessional caregivers (with or without the member present), the service:

- must focus on and be on behalf of the member, and
- may include the training of family members or nonprofessional caregivers to:
  - Monitor the member's medication compliance
  - Assist with the administration of prescribed medications
  - Monitor side effects, including:
    - Weight
    - Blood glucose level
    - Blood pressure

AMHH medication and training support services are able to be provided in a variety of settings:

- to the member individually in either an individual setting or a group setting, or
- to family members or other nonprofessional caregivers, in an individual or group setting, **with or without** the member present.

Refer to *Appendix A* for the definitions of individual and group settings as they apply to this service.

In addition to face-to-face services provided to a member and/or a member's family, there are some AMHH medication training and support services that are not required to be provided face-to-face. These include *(note: these services may only be provided in an individual setting)*:

- transcribing medication orders of a physician or AHCP
- setting or filling medication boxes
- consulting with the attending physician or AHCP regarding medication-related issues
- Ensuring linkage that lab and/or other prescribed clinical orders are sent.
- Ensuring that the member follows through and receives lab work and services pursuant to other clinical orders.
- Follow-up reporting of lab and clinical test results to the member and physician.

PROVIDER QUALIFICATIONS

Provider staff delivering AMHH medication training and support services must meet one (1) of the following qualifications:

- A licensed physician.
- An authorized health care professional (AHCP).
- A licensed registered nurse (RN).
- A licensed practical nurse (LPN).

- A medical assistant (MA) who has graduated from a two year clinical program.

Refer to *Section 3: AMHH Service Providers* for additional information on provider agency and staff member qualifications.

PROGRAMMING STANDARDS

Programming standards for AMHH medication training and support services include the following:

- Services must be provided within the scope of practice as defined by federal and state law.
- Services provided that are not face-to-face with the member must meet the following standards:
  - The member must be the focus of the service.
  - Documentation must support how the service benefits the member.
- When provided in a clinic setting, AMHH medication training and support services may complement, but not duplicate, activities associated with medication management activities as defined by and available under the Medicaid Clinic Option.
- When provided in a residential treatment setting, AMHH medication training and support services may include components of medication management services as defined under the Medicaid Clinic Option.
- Services must be habilitative in nature and demonstrate movement toward and/or achievement of the member's treatment goals identified on the IICP.

EXCLUSIONS

General AMHH program exclusions are outlined in the *Non-Covered Services* subsection in *Section 2: AMHH Services*. The following specific exclusions apply, and are non-reimbursable/non-covered, for AMHH medication training and support services:

- If Medicaid Clinic Option medication management, counseling or psychotherapy is provided and medication management is a component of the service, then AMHH medication training and support services may not be billed separately for the same visit by the same provider.
- Coaching and instruction regarding member self-administration of medications is not reimbursable under AMHH medication training and support, but may be eligible for reimbursement under Home and Community-Based Habilitation and Support skills training and development.
- Services provided to paid, professional caregivers.
- When provided *in a group setting*, the following activities *are not covered*:
  - Transcribing physician or AHCP medication orders.
  - Setting or filling medication boxes.
  - Consulting with the attending physician or AHCP regarding medication-related issues.
  - Ensuring linkage that lab and/or other prescribed clinical orders are sent.
  - Ensuring that the member follows through and receives lab work and services pursuant to other clinical orders.
  - Follow-up reporting of lab and clinical test results to the member and physician.

HCPCS

Service Table 23.1 – HCPCS Codes for Medication Training and Support Services

Code	Modifiers	Code Description
H0034	UB	Medication Training and Support – Individual Setting; 1 Unit = 15 minutes

H0034	UB; HR	Medication Training and Support – Family/Couple with Member Present (Individual Setting); 1 Unit = 15 minutes
H0034	UB; HS	Medication Training and Support – Family/Couple without Member Present (Individual Setting); 1 Unit = 15 minutes
H0034	UB; U1	Medication Training and Support – Group Setting; 1 Unit = 15 minutes
H0034	UB; U1; HR	Medication Training and Support – Family/Couple with Member Present (Group Setting); 1 Unit = 15 minutes
H0034	UB; U1; HS	Medication Training and Support – Family/Couple without Member Present (Group Setting); 1 Unit = 15 minutes

SERVICE UNIT DESCRIPTION AND LIMITATIONS

The basic unit of service for AMHH medication training and support services is a 15-minute unit. AMHH medication and training support services, including all subtypes (individual or group setting, family/couple, with and without member present), may be provided for a maximum of 182 hours (728 units) per AMHH eligibility period.

SECTION 24: AMHH SERVICES PROGRAM BILLING

This section outlines AMHH billing guidelines, claim format, and necessary billing-related information. Explanation of billing specifics such as actual time spent conducting service versus time billed, modifiers, and other helpful billing-related items are included with examples. For more information about general billing, see 405 IAC 1 and *Chapter 8: Billing Instructions* of the *IHCP Provider Manual*. IHCP providers are responsible for reading and understanding applicable IAC and IHCP manuals.

BILLING STANDARDS

AMHH provider agencies that are enrolled IHCP providers must adhere to all IHCP rules, policies and processes required of IHCP enrolled members.

In regards to AMHH services, the following applies:

- IHCP rendering provider numbers are assigned to physicians or HSPPs. The rendering provider numbers are linked to the group provider number of the participating billing group.
- Reimbursement is 100% of the rate for all staff meeting provider qualifications for each service.
- Providers are responsible for internally tracking AMHH service utilization to ensure that service units are available. Provider can confirm service unit availability via Web interChange, the State's recognized final reference for this information.
- Units of AMHH services, as displayed in Web interChange, are decremented based on adjudicated claims. Failure to submit claims in a timely fashion may place the provider at risk for nonpayment.
- For an AMHH provider to receive reimbursement for the delivery of AMHH services, a member must have been deemed eligible for AMHH services and received an authorization notification confirming the AMHH services authorized on the IICP. The FSSA/DMHA SET retains final authority for determining AMHH eligibility and authorizing AMHH services.
- AMHH approval and authorization dates may be accessed by providers on Web interChange: https://interchange.indianamedicaid.com/Administrative/logon.aspx.
- Providers of AMHH Services are IHCP Providers and therefore are responsible for complying with IHCP billing practices outlined at www.indianamedicaid.com.

CLAIM FORM

Each line of the *CMS-1500* claim form is individually priced at the IHCP allowed rate for the procedure billed. The IHCP allowed rate is the lower of the submitted charge or the IHCP maximum fee for that procedure.

Each line on the *CMS-1500* claim form accommodates a rendering provider number. Multiple rendering provider numbers can be reflected on one claim to indicate the individual practitioner in the group that performed each service billed on the claim form. The rendering provider's NPI and taxonomy (optional) is included in field 33b of the claim form. The group's billing provider NPI is included in field 33a, and taxonomy (optional) is included in field 33b of the claim form. The group provider number is used for billing and incorporates all the individual provider services on the group RA. A provider who is not a physician or an HSPP is not assigned an individual IHCP provider number. For detailed, line-by-line billing instructions for the *CMS-1500* (08/05), see *Chapter 8* of the *IHCP Provider Manual*.

CLAIM FORMAT

AMHH service claims can be billed using the *CMS-1500* paper claim format or the HIPAA-compliant electronic 837P claim format. Additional procedures for billing with the *CMS-1500* claim form are provided in *Chapter 8* of the *IHCP Provider Manual*.

The following instructions must be followed for billing claims to the IHCP for AMHH services:

- The provider agency billing group's NPI must be entered in field 33a of the *CMS-1500* claim form.
- Each line of the *CMS-1500* claim form must include the rendering or supervising psychiatrist, physician, or HSPP's NPI in field 24J.

AMHH services may be billed with other IHCP-covered services on the same claim. Updated information is disseminated through IHCP provider bulletins posted on www.indianamedicaid.com. Each provider is responsible for obtaining the information and implementing new or revised policies and procedures as outlined in these notices.

Note: Submit claims for reimbursement on a timely basis:

- Units of AMHH services as displayed in Web interChange are decremented based on adjudicated claims.
- Timely submission of claims will ensure that the data accessible on Web interChange accurately reflects remaining units of service for each member.
- Failure to submit claims timely may place the provider at risk for nonpayment.

Facility Fees

No facility fees are paid for AMHH services.

AMHH and the Healthy Indiana Plan (HIP)

Individuals who are enrolled in Healthy Indiana Plan (HIP) 2.0 program who are determined to be medically frail, have access to coverage established under the Indiana Medicaid State Plan. The State Plan services include intensive behavioral health Medicaid programs such as MRO/BPHC/AMHH. The intensive community-based behavioral health service programs are carved out from the HIP managed care entities (MCE's) benefit responsibilities and are billed to the IHCP through the fee-for-service claims payment system.

HIP members deemed medically frail will receive HIP State Plan coverage and will be enrolled in HIP State Plan – Plus, and are required to make monthly POWER Account contributions. HIP State Plan – Plus members are not subject to co-pays for most services, including all AMHH behavioral health services. Medically frail members enrolled in HIP State Plan – Plus who do not pay their monthly POWER Account contributions will be enrolled in HIP State Plan – Basic, and are required to pay a $4 co-pay for outpatient services, including many AMHH services. Table 24.1 identifies the AMHH service types which do not require copayment.

Table 24.1 − AMHH procedure codes with modifiers that do not require a copayment under HIP State Plan Basic

Procedure code	Modifiers	Service title
H2014	UB; HS	Home and Community-based Habilitation and Support Services- Family/Couple without the Member Present (Individual Setting); 15 minute unit
H2014	UB; U1; HS	Home and Community-based Habilitation and Support Services- Family/Couple without Member Present (Group Setting); 15 minute unit
H0004	UB; HS	Therapy and Behavioral Support Services – Family/Couple without Member Present (Individual Setting); 1 Unit = 15 minutes
H0004	UB; U1; HS	Therapy and Behavioral Support Services – Family/Couple without Member Present (Group Setting); 1 Unit = 15 minutes
H2035	UB; HS	Addiction Counseling – Family/Couple without Member Present (Individual Setting); 1 Unit = 1 hour
H2035	UB; U1; HS	Addiction Counseling – Family/Couple without Member Present (Group Setting); 1 Unit = 1 hour
H0038	UB	Peer Support Services; 1 Unit = 15 minutes
T1016	UB	Care Coordination Services; 1 Unit = 15 minutes
H0034	UB	Medication Training and Support – Individual Setting; 1 Unit = 15 minutes
H0034	UB; HR	Medication Training and Support – Family/Couple with Member Present (Individual Setting); 1 Unit = 15 minutes
H0034	UB; HS	Medication Training and Support – Family/Couple without Member Present (Individual Setting); 1 Unit = 15 minutes
H0034	UB; U1	Medication Training and Support – Group Setting; 1 Unit = 15 minutes
H0034	UB; U1; HR	Medication Training and Support – Family/Couple with Member Present (Group Setting); 1 Unit = 15 minutes
H0034	UB; U1; HS	Medication Training and Support – Family/Couple without Member Present (Group Setting); 1 Unit = 15 minutes

More information about the HIP program can be found at the FSSA HIP website, http://www.in.gov/fssa/hip/index.htm.

TIME DOCUMENTATION

Staff must document actual time spent delivering services in a 24-hour period within the member's clinical record. For billing purposes, a provider agency must total the actual time spent delivering the same service on the same day by all provider types for each member. Minutes of service do not have to be consecutive to be billed together. When services are provided in group settings, it is appropriate to bill for each member in the group for the time spent in the group.

Examples: *Time Documentation*

Example A-1:

A member receives five (5) minutes of Habilitation services from a staff member, four (4) minutes of Habilitation services from a second staff member, and nine (9) minutes of Habilitation services from a third staff member on the same day. The member's clinical record notes that three staff members provided Habilitation services on the same day and the amount of time each staff person spent with the member. For time documentation purposes, the total actual time spent is 18 minutes.

5 minutes + 4 minutes + 9 minutes = 18 minutes of Habilitation services

Example A-2:

A member receives fifteen (15) minutes of Therapy and Behavioral Support services, Individual, from an LCSW and twenty-five (25) minutes of Therapy and Behavioral Support services, Individual, from a master's level practitioner on the same day. The member's clinical record notes that two staff members provided Therapy and Behavioral Support services, Individual, on the same day and the amount of time each staff person spent with the member. For time documentation purposes, the total actual time spent is 40 minutes. Even though the two staff members have different provider qualifications, they must add their time spent with the member together.

15 minutes + 25 minutes = 40 Minutes of Therapy and Behavioral Support services, Individual

CONVERTING TIME SPENT FOR SERVICE DELIVERY TO BILLING UNITS

Providers must determine the total actual time spent delivering a given service in a 24-hour period, as described in above in *Time Documentation.* The total time spent is then converted into billing units for that service. Providers should refer to the HCPCS code for each service for information on the unit increment that is used for each service. Providers should round the total actual time each day to the nearest whole unit when calculating reimbursement, as described below.

15-MINUTE UNIT

Services billed in 15-minute units include: home and community-based habilitation and support, therapy and behavioral support, peer support, supported community engagement, care coordination, and medication training and support (see subsection below for unique billing guidance for respite care services). If staff delivers one of these services for eight or more minutes, or the total daily minutes for the service add up to eight or more minutes, the provider may round up to one 15-minute unit. If staff delivers a service for seven minutes or less, or the total daily minutes for the service add up to seven minutes or less, the provider rounds down to zero units and therefore may not bill for the service. The same rounding rules apply to portions of time remaining once one or more full 15-minute units have been converted.

***Examples:** 15-Minute Unit Billing*

Example B-1:

The member (from Example A-1 above) received eighteen (18) total minutes of Habilitation services from three different staff members in a 24-hour period, as reflected in the member's clinical record. Habilitation services are billed in 15-minute units, so for billing purposes, only one (1) unit of Habilitation services may be billed.

18 minutes of Habilitation = One 15 minute unit of Habilitation.
(one full 15-minute unit plus 3 additional minutes, which must be rounded down)

Example B-2:

The member (from Example A-2 above) received forty (40) minutes of Therapy and Behavioral Support, Individual, from two different providers on the same day, as reflected in the member's clinical record. Therapy and Behavioral Support services are billed in 15-minute units, so for billing purposes, three (3) units of Therapy and Behavioral Support services may be billed.

40 Minutes of Therapy and Behavioral Support = Three 15 minute units of Therapy and Behavioral Support.
(two full 15-minute units plus 10 additional minutes, which may be rounded up)

ONE-HOUR (60-MINUTE) UNIT

AMHH addiction counseling services are billed in one-hour (60-minute) units. If staff delivers an addiction counseling service for 45 or more minutes, or the total minutes of addiction counseling service provided for the day adds up to 45 or more minutes, the provider may bill for the appropriate number of units of addiction counseling. If staff delivers an addiction counseling service for 44 minutes or less, or the total minutes of addiction counseling service provided for the day adds up to 44 minutes or less, the provider rounds down to zero units and therefore may not bill for this service. The same rounding rules apply to portions of time remaining, once one or more full one-hour (60-minute) units have been converted.

***Example:** One-Hour Unit Billing*

A member receives 48 minutes of Addiction Counseling services, Individual. For billing purposes, 48 minutes of service is greater than (>) the 44-minute threshold, and the provider may round up to one one-hour unit.

48 minutes > 44-minute threshold = provider may bill for one 1-hour unit of Addiction Counseling.

A member receives 25 minutes of Addiction Counseling services. For billing purposes, 25 minutes of service is less than (<) the 44-minute threshold. The provider must round down to zero (0) and *may not bill* for this service.

25 minutes < 44 minutes = provider may not bill for Addiction Counseling services rendered,

A member receives 20 minutes of Addiction Counseling services from one staff member and 25 minutes of Addiction Counseling services from a second staff member on the same day. The provider totals the actual time delivering the service to 45 minutes. For billing purposes, 45 minutes of service is greater than the 44-minute threshold, and the provider rounds up to one one-hour unit.

20 minutes + 25 minutes = 45 minutes > 44 minutes threshold = provider may bill for one 1-hour unit of Addiction Counseling services.

A member receives 80 minutes of Addiction Counseling, Group. For billing purposes, 80 minutes is greater than the 44-minute threshold for one 1-hour unit of service, but does not qualify for a second one-hour unit of service.

80 minutes = 60 minutes (One 1 hour unit of service) + 20 minutes;

20 minutes < 44-minute threshold = provider may bill for one 1-hour unit of Addiction Counseling, Group and may not bill the additional 20 minutes of services rendered.

HALF-DAY UNITS

AMHH adult day service is the only AMHH service that is billed in *half-day units,* which consist of a minimum of three (3) and maximum of five (5) consecutive hours of the service. Up to 20 minutes in break-time may occur within the minimum three-hour block of service time. If more than three (3) consecutive hours are provided, up to a 60-minute break is allowed in addition to the 20-minute break. The 60-minute break may not be billed as a component of the service, however.

Adult day service allows for up to two (2) half-day units of service to be billed in one day. The second half-day unit may be billed only if a previous half-day unit equaling five (5) hours has been delivered and an additional three (3) hours of the service is provided. The second unit of service may include an additional 20-minute break within the three-hour block of time.

Example: *Half-Day Unit Billing*

A member receives 53 minutes of Adult Day services followed by a 10-minute break, an additional 50 minutes of Adult Day services followed by a 10-minute break, and finally an additional 60 minutes of Adult Day services. A total of 163 minutes of member contact was provided, and with the allowable 20 minutes of break time, a total of 183 minutes of Adult Day services was delivered (183 minutes is greater than (>) the 180 minute unit).

183 minutes > 180 minutes = provider may bill for one (1) half-day unit of Adult Day services.

A member receives 30 minutes of Adult Day services followed by a 10-minute break, then an additional 30 minutes of Adult Day services followed by a 10-minute break, and finally an additional 30 minutes of Adult Day services. A total of 90 minutes of member contact was provided, and with the allowable 20 minutes of break time, a total of 110 minutes of Adult Day Services was delivered (110 minutes is less than (<) the 180 minute unit).

110 minutes < 180 minutes = provider may not bill for the Adult Day services rendered.

RESPITE CARE AND SINGLE-DAY UNITS

AMHH respite care may be billed in two separate ways, depending on the length of time the service was provided during a 24-hour period. Respite care is billed in *15-minute units* when provided for less than seven (7) hours per day, and in *single-day units* when the service is provided for a minimum of eight (8) hours up to a maximum of twenty-four (24) hours in a 1-day period.

Note: "Hourly" respite care and "daily" respite care may not be billed on the same date of service!

Examples: *Respite Care Billing*

A member receives 204 minutes of respite care in a calendar day, which equates to 3 hours and 24 minutes. Since this is less than 7 hours, the provider may bill for total of fourteen (14) 15-minute units of "hourly rate" respite care.

3 hours x 4 units/hour = 12 units, plus 24 minutes = one 15-minute unit plus 9 additional minutes, rounded up to another whole unit, totaling 14 units.

A member receives 14 hours of respite care services in a calendar day. Since this is more than 7 hours, the provider may bill for one (1) single-day unit of respite care.

MODIFIERS FOR AMHH SERVICES

The following modifiers are needed for the submission of AMHH claims.

Table 24.1 – Service Modifiers

Modifier	Service Description
U1	Group setting
HR	Family/couple with client present
HS	Family/couple without client present
UB	Face-to-face encounter

MIDLEVEL PROVIDER MODIFIERS

Midlevel provider modifiers should not be used when submitting AMHH services claims. The use of midlevel provider modifiers results in the denial of the AMHH services claim.

THIRD-PARTY LIABILITY (TPL) REQUIREMENTS

To ensure that the IHCP does not pay for services covered by other insurance sources, federal regulations (*42 CFR 433.139*) require that the IHCP be the payer of last resort. With some exceptions, providers are required to bill all liable third parties before submitting a claim to the IHCP. This activity is commonly referred to as cost avoidance. AMHH services are exempt from TPL cost avoidance editing and can be billed directly to the IHCP.

PLACE OF SERVICE CODES

AMHH services can be rendered in the following locations with the place of service code listed:

- 12 – Home
- 99 – Other unlisted facility (such as employment or a community place)
- 53 – Community Mental Health Center (CMHC)

MAILING ADDRESS FOR CLAIMS

AMHH claims are sent to the standard medical claim address:

HP CMS-1500 Claims
P.O. Box 7269
Indianapolis, IN 46207-7269

ADDITIONAL ADDRESSES AND TELEPHONE NUMBERS

Providers should direct questions about filing claims to Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278. The addresses and telephone numbers are also available on the *IHCP Quick Reference* on www.indianamedicaid.com.

APPENDIX A: AMHH ACRONYMS AND DEFINITIONS

The following acronyms and definitions apply to AMHH services and the policy and procedures outlined in the AMHH Provider Manual:

Adult Mental Health Habilitation (AMHH) refers to medical or remedial services recommended by a physician or other licensed professional, within the scope of his or her practice, for the habilitation of a mental disability and the restoration or maintenance of an individual's best possible functional level. Services are clinical and supportive behavioral health services that are provided for individuals, families, or groups of adult persons who are living in the community and who need aid on a routine basis for a mental illness or co-occurring mental illness and addiction disorders.

AMHH behavioral health habilitation services include the following:

- Adult day services
- Home and community-based habilitation and support
- Respite care
- Therapy and behavior support services
- Addiction counseling
- Peer support services
- Supported community engagement services
- Care coordination
- Medication training and support

Adult Needs and Strengths Assessment (ANSA) is the approved Division of Mental Health and Addiction (FSSA/DMHA) behavioral health assessment tool, administered by a qualified individual who is trained and FSSA/DMHA-certified to administer the tool, in order to assist in determining the level of need and functional impairment of an applicant or member.

Applicant means an individual applying for AMHH services by inquiring about AMHH services or completing the AMHH application process.

Assistance means any kind of support given due to a behavioral health condition or disorder including but not limited to the following:

- Mentoring
- Supervision
- Reminders
- Verbal cueing
- Hands-on assistance

Authorized Healthcare Professional (AHCP) means any of the following persons:

- A physician assistant with the authority to prescribe, dispense and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5.
- A nurse practitioner or clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to IC 25-23-1.

Community-Based: AMHH services are approved by CMS to be provided within the individual's home (or place of residence) or at other locations based in the community (outside of an institutional setting). Refer to *Section 6: AMHH Member Home and Community-Based Residence Requirements* for additional information regarding community-based settings.

Certified Recovery Specialist (CRS) means an individual meeting the FSSA/DMHA training and competency standards for a CRS.

Detoxification services means services or activities that are provided to a member during his or her withdrawal from alcohol and other addictive drugs, while under the direct supervision of a physician or clinical nurse specialist.

FSSA/DHMA refers to the Indiana Family and Social Services Administration's Division of Mental Health and Addiction.

Group setting: A g*roup setting* means that the activity is meant to benefit more than one consumer, and may include family members and/or nonprofessional caregivers of multiple consumers, whether or not the consumers are present during the activity. The benefit to the consumer must be in accordance with each consumer's individual treatment goals.

> *Example:* The families of several consumers meet for an orientation session to an upcoming AMHH skills development group, which will be attended by several AMHH consumers. Since the group will include more than one consumer, it is considered a group setting.

Habilitation services means activities that are designed to assist individuals in acquiring, retaining, and improving the following skills necessary to reside successfully in community settings: self-help, socialization, and adaptive skills.

Individualized Integrated Care Plan (IICP) means a treatment plan that:

- Integrates all components and aspects of care that are deemed medically necessary, are clinically indicated, and are provided in the most appropriate setting to achieve the individual's goals;
- Includes all indicated medical and support services needed by the individual in order to:
    - Remain in the community.
    - Function at the highest level of independence possible.
    - Achieve goals identified in the IICP.
- Is developed for each individual.
- Is developed with the individual.
- Reflects the individual's desires and choices.

Indiana*AIM*: Indiana's MMIS or claims payment system.

Individual setting: An *individual setting* means that the activity is meant to benefit one consumer, and may include family members and/or nonprofessional caregivers, whether or not the consumer is present during the activity

> *Example:* An AMHH consumer "John" attends a family counseling session with his siblings and mother. Since the session is intended to benefit only John, it is considered an individual setting, even though multiple people are present.

Level of Need means a recommended intensity of behavioral health services based on a pattern of an individual's needs, as determined by using a standardized assessment tool.

Licensed Professional means any of the following persons:

- A licensed psychiatrist.
- A licensed physician.
- A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP).
- A licensed clinical social worker (LCSW).

- A licensed mental health counselor (LMHC).
- A licensed marriage and family therapist (LMFT).
- A licensed clinical addiction counselor (LCAC), as defined under IC 25-23.6-10.5.

Medicaid rehabilitation services means any medical or remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a member to his best possible level of functioning.

Nonprofessional caregiver means any individual who does not receive compensation for providing care or services to a Medicaid member.

Office or **FSSA/OMPP** refers to the Indiana Family and Social Services Administration's Office of Medicaid Policy and Planning.

Other Behavioral Health Professional (OBHP) means any of the following:

- An individual with an associate or bachelor degree, or equivalent behavioral health experience, meeting minimum competency standards set forth by a behavioral health service provider and supervised by either a licensed professional or a QBHP.
- A licensed addiction counselor, as defined under IC 25-23.6-10.5, supervised by either a licensed professional or a QBHP.

Professional caregiver means an individual who receives payment for providing services and supports to a Medicaid member.

Provider agency means any FSSA/DMHA-approved agency that meets the qualifications and criteria to become an AMHH provider agency.

Provider staff means any individual working under a FSSA/DMHA-approved AMHH provider agency that meets the qualifications and requirements mandated by the AMHH service being provided.

Qualified Behavioral Health Professional (QBHP) means any of the following:

- An individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, with such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines from an accredited university:
    - Psychiatric or mental health nursing, plus a license as a registered nurse in Indiana.
    - Pastoral counseling.
    - Rehabilitation counseling.
- An individual who is under the supervision of a licensed professional, is eligible for and working towards professional licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines from an accredited university:
    - Social work from a university accredited by the Council on Social Work Education.
    - Psychology.
    - Mental health counseling.
    - Marital and family therapy.
- A licensed independent practice school psychologist under the supervision of a licensed professional.
- An authorized health care professional (AHCP) who is one (1) of the following:
    - A physician assistant with the authority to prescribe, dispense and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5.

- A nurse practitioner or clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to IC 25-23-1.

Member means an individual who has been deemed eligible for AMHH services by the FSSA/DMHA SET.

Recreational means activities people do to relax or have fun (e.g., activities done for enjoyment).

Self-Help means a self-guided improvement in functioning through the use of supports and resources.

Significant means an assessed need for immediate or intensive action due to a serious or disabling need.

Skills training means services or activities to further the reinforcement, management, adaptation and retention of skills necessary for the individual to live successfully in the community.

State Evaluation Team (SET) means the FSSA/DMHA independent evaluation team that will review and assess all evaluation information and supporting clinical documentation collected for AMHH applications and members, and will be responsible for making final determinations regarding the following:

- Eligibility of applicants for AMHH services.
- Authorization for AMHH services for eligible members.
- Continued eligibility determination for AMHH members.
- Appropriate service delivery to AMHH members, as a result of conducting quality improvement reviews of AMHH service provider agencies.

Web interChange: Electronic portal where AMHH authorization information may be viewed by AMHH providers. Link is https://interchange.indianamedicaid.com/Administrative/logon.aspx.

APPENDIX B: AMHH SERVICES PROGRAM-ELIGIBLE DIAGNOSIS CODES

AMHH eligible members must have one or more of the AMHH-eligible mental health, as outlined in *Section 5: AMHH Program Member Eligibility*.

All diagnoses are Axis I

Updated: October 2013

Code	Name	Code Type
295	Schizophrenic Disorders	ICD-9
295.0	Simple Schizophrenia	ICD-9
295.00	Simple Schizophrenia, Unspecified	ICD-9
295.01	Simple Schizophrenia, Sub-chronic	ICD-9
295.02	Simple Schizophrenia, Chronic	ICD-9
295.03	Simple Schizophrenia, Sub-chronic with Acute Exacerbation	ICD-9
295.04	Simple Schizophrenia, Chronic with Acute Exacerbation	ICD-9
295.1	Hebephrenia	ICD-9
295.1	Schizophrenia, Disorganized Type	DSM-IV-TR
295.11	Hebephrenia, Sub-chronic	ICD-9
295.12	Hebephrenia, Chronic	ICD-9
295.13	Hebephrenia, Sub-chronic with Acute Exacerbation	ICD-9
295.14	Hebephrenia, Chronic with Acute Exacerbation	ICD-9
295.2	Catatonic Schizophrenia	ICD-9
295.2	Schizophrenia, Catatonic Type	DSM-IV-TR
295.21	Catatonia, Sub-chronic	ICD-9
295.22	Catatonia, Chronic	ICD-9
295.23	Catatonia, Sub-chronic with acute Exacerbation	ICD-9
295.24	Catatonia, Chronic with Acute Exacerbation	ICD-9
295.3	Paranoid Schizophrenia	ICD-9
295.3	Schizophrenia, Paranoid Type	DSM-IV-TR
295.31	Paranoid Schizophrenia, Sub-chronic	ICD-9
295.32	Paranoid Schizophrenia, Chronic	ICD-9
295.33	Paranoid Schizophrenia, Sub-chronic with Acute Exacerbation	ICD-9
295.34	Paranoid Schizophrenia, Chronic with Acute Exacerbation	ICD-9
295.4	Acute Schizophrenic Episode	ICD-9
295.41	Acute Schizophrenic Episode, Sub-chronic	ICD-9
295.42	Acute Schizophrenic Episode, Chronic	ICD-9
295.43	Acute Schizophrenic Episode, Sub-chronic with Acute Exacerbation	ICD-9
295.44	Acute Schizophrenic Episode, Chronic with Acute Exacerbation	ICD-9
295.5	Latent Schizophrenia	ICD-9
295.51	Latent Schizophrenia, Sub-chronic	ICD-9
295.52	Latent Schizophrenia, Chronic	ICD-9

295.53	Latent Schizophrenia, Sub-chronic with Acute Exacerbation	ICD-9
295.54	Latent Schizophrenia, Chronic with Acute Exacerbation	ICD-9
295.6	Residual Schizophrenia	ICD-9
295.6	Schizophrenia, Residual Type	DSM-IV-TR
295.61	Schizophrenia, Residual Type, Sub-chronic	ICD-9
295.62	Schizophrenia, Residual Type, Chronic	ICD-9
295.63	Schizophrenia, residual Type, Sub-chronic with Acute Exacerbation	ICD-9
295.64	Schizophrenia, Residual Type, Chronic with Acute Exacerbation	ICD-9
295.7	Schizoaffective Type*	ICD-9
295.7	Schizoaffective Disorder	DSM-IV-TR
295.71	Schizoaffective Disorder, Sub-chronic	ICD-9
295.72	Schizoaffective Disorder, Chronic	ICD-9
295.73	Schizoaffective Disorder, Sub-chronic with Acute	ICD-9
295.74	Schizoaffective Disorder, Chronic with Acute Exacerbation	ICD-9
295.8	Schizophrenia NEC	ICD-9
295.81	Schizophrenia NEC, Sub-chronic	ICD-9
295.82	Schizophrenia NEC, Chronic	ICD-9
295.83	Schizophrenia NEC, Sub-chronic with Acute Exacerbation	ICD-9
295.84	Schizophrenia NEC, Chronic with Acute Exacerbation	ICD-9
295.9	Schizophrenia NOS	ICD-9
295.90	Schizophrenia NOS, Chronic	DSM-IV-TR
295.91	Schizophrenia NOS, Sub-chronic with Acute Exacerbation	ICD-9
295.92	Schizophrenia NOS, Chronic with Acute Exacerbation	ICD-9
295.93	Schizophrenia NOS, Sub-chronic with Acute Exacerbation	ICD-9
295.94	Schizophrenia, NOS, Chronic with Acute Exacerbation	ICD-9
296	Bipolar I Disorder, Single Manic Episode, Unspecified	DSM-IV-TR
296.02	Bipolar I Disorder, Single Manic Episode, Moderate	DSM-IV-TR
296.03	Bipolar I Disorder, Single Manic Episode, Severe Without Psychotic Features	DSM-IV-TR
296.04	Bipolar I Disorder, Single Manic Episode, Severe With Psychotic Features	DSM-IV-TR
296.05	Bipolar I Disorder, Single Manic Episode, In Partial Remission	DSM-IV-TR
296.1	Manic, Recurrent Episode	ICD-9
296.1	Bipolar I Disorder, single Manic Episode, Mild	ICD-9
296.12	Manic Disorder, Recurrent Episode, Moderate	ICD-9
296.13	Manic Disorder, Recurrent Episode, Severe, Without Psychotic Features	ICD-9
296.14	Manic Disorder, Recurrent Episode, with Psychotic Features	ICD-9
296.3	Bipolar I Disorder, Single Manic Episode, Severe Without Psychotic Features	ICD-9
296.3	Major Depressive Disorder, Recurrent, Unspecified	DSM-IV-TR
296.32	Major Depressive Disorder, Recurrent, Moderate	DSM-IV-TR
296.33	Major Depressive Disorder, Recurrent, Severe Without Psychotic Features	DSM-IV-TR

296.34	Major Depressive Disorder, Recurrent, Severe With Psychotic Features	DSM-IV-TR
296.4	Bipolar Affective, Manic	ICD-9
296.4	Bipolar I Disorder, Most Recent Episode Hypomanic or Manic, Unspecified	DSM-IV-TR
296.42	Bipolar I Disorder, Most Recent Episode Manic, Moderate	DSM-IV-TR
296.43	Bipolar I Disorder, Most Recent Episode Manic, Severe Without Psychotic Features	DSM-IV-TR
296.44	Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features	DSM-IV-TR
296.45	Bipolar I Disorder, Most Recent Episode Manic, In Partial Remission	DSM-IV-TR
296.5	Bipolar Affect, Depression	ICD-9
296.5	Bipolar I Disorder, Most Recent Episode Depressed, Unspecified	DSM-IV-TR
296.52	Bipolar I Disorder, Most Recent Episode Depressed, Moderate	DSM-IV-TR
296.53	Bipolar I Disorder, Most Recent Episode Depressed, Severe Without Psychotic Features	DSM-IV-TR
296.54	Bipolar I Disorder, Most Recent Episode Depressed, Severe With Psychotic Features	DSM-IV-TR
296.55	Bipolar I Disorder, Most Recent Episode Depressed, In Partial Remission	DSM-IV-TR
296.6	Bipolar Affective Mixed	ICD-9
296.60	Bipolar I Disorder, Most Recent Episode Mixed, Unspecified	DSM-IV-TR
296.62	Bipolar I Disorder, Most Recent Episode Mixed, Moderate	DSM-IV-TR
296.63	Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features	DSM-IV-TR
296.64	Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features	DSM-IV-TR
296.65	Bipolar I Disorder, Most Recent Episode Mixed, In Partial Remission	DSM-IV-TR
296.7	Bipolar I Disorder, Most Recent Episode Unspecified	DSM-IV-TR
296.8	Manic-Depressive NEC/NOS	ICD-9
296.80	Bipolar Disorder NOS	DSM-IV-TR
296.81	Atypical Manic Disorder	ICD-9
296.82	Atypical Depressive Disorder	ICD-9
296.89	Bipolar II Disorder	DSM-IV-TR
297.1	Delusional Disorder	DSM-IV-TR
298.9	Psychotic Disorder NOS	DSM-IV-TR
300.3	Obsessive-Compulsive Disorder	DSM-IV-TR

APPENDIX C: AMHH SERVICE CODES AND RATES TABLE

AMHH Service	HCPCS Code	Modifier	Unit/Rate
Adult Day Services	S5101	UB	$28.80/ per half day unit
HCB Habilitation with Member (Individual setting)	H2014	UB	$26.14 per 15 minute unit.
HCB Habilitation with Family and Member (Individual setting)	H2014	UB HR	$26.14 per 15 minute unit.
HCB Habilitation with Family ,without the Member present (Individual setting)	H2014	UB HS	$26.14 per 15 minute unit.
HCB Habilitation with Member (Group setting)	H2014	UB U1	$4.71 per 15 minute unit.
HCB Habilitation with Family and Member (Group setting)	H2014	UB U1 HR	$4.71 per 15 minute unit.
HCB Habilitation with Family without the Member present (Group setting)	H2014	UB U1 HS	$4.71 per 15 minute unit.
Respite (Hourly)	S5150	UB	$3.50 per 15 minute unit
Respite (Daily)	S5151	UB	$98.00 per 1-day unit
Therapy and Behavioral Support Services with Member (Individual setting)	H0004	UB	$28.65 per 15 minute unit
Therapy and Behavioral Support Services with Family and Member (Individual setting)	H0004	UB HR	$28.65 per 15 minute unit
Therapy and Behavioral Support Services without the Member present (Individual setting)	H0004	UB HS	$28.65 per 15 minute unit
Therapy and Behavioral Support Services with Member (Group setting)	H0004	UB U1	$7.16 per 15 minute unit
Therapy and Behavioral Support Services with Family and Member (Group setting)	H0004	UB U1 HR	$7.16 per 15 minute unit
Therapy and Behavioral Support Services without the Member present (Group setting)	H0004	UB U1 HS	$7.16 per 15 minute unit
Addiction Counseling with Member (Individual setting)	H2035	UB	$58.32 per 1 hour unit
Addiction Counseling with Family and Member (Individual setting)	H2035	UB HR	$58.32 per 1 hour unit
Addiction Counseling with Family without the Member present (Individual setting)	H2035	UB HS	$58.32 per 1 hour unit

AMHH Service	HCPCS Code	Modifier	Unit/Rate
Addiction Counseling with Member (Group setting)	H2035	UB U1	$14.58 per 1 hour unit
Addiction Counseling with Family and Member (Group setting)	H2035	UB U1 HR	$14.58 per 1 hour unit
Addiction Counseling with Family without the Member present (Group setting)	H2035	UB U1 HS	$14.58 per 1 hour unit
Peer Support Services	H0038	UB	$8.55 per 15 minute unit
Supported Community Engagement Services	97537	UB	$26.14 per 15 minute unit
Care Coordination	T1016	UB	$14.53 per 15 minute unit
Medication Training and Support with Member (Individual setting)	H0034	UB	$18.62 per 15 minute unit
Medication Training and Support with Family and Member (Individual setting)	H0034	UB HR	$18.62 per 15 minute unit
Medication Training and Support with Family without the Member present (Individual setting)	H0034	UB HS	$18.62 per 15 minute unit
Medication Training and Support with Member (Group setting)	H0034	UB U1	$3.35 per 15 minute unit
Medication Training and Support with Family and Member (Group setting)	H0034	UB U1 HR	$3.35 per 15 minute unit
Medication Training and Support with Family without the Member present (Group setting)	H0034	UB U1 HS	$3.35 per 15 minute unit

APPENDIX D: AMHH DENIAL NOTIFICATION SAMPLE

FSSA/Indiana Division of Mental Health and Addiction
Indiana Government Center South
402 W. Washington Street, W353
Indianapolis, Indiana 46204
Office: 317-232-7800
Secure Fax: 317-233-1986

Date: MM/DD/YYYY

Indiana Medicaid Adult Mental Health Habilitation (AMHH) Services **DENIAL** Notification

Member Information	Provider Information
Member Name Member Address City, State, ZIP RID:	Provider Provider Address City, State, ZIP Submitted by: (DMHA SET staff)

The Division of Mental Health and Addiction (DMHA) has received your application for the Adult Mental Health Habilitation (AMHH) Services Program. You are receiving this notice because your application has been denied. This notice explains why your application has been determined as not meeting the eligibility criteria for the AMHH program and what your appeal rights are if you do not agree with the determination. **Please contact the provider who assisted in completing and submitting your application to discuss options and next steps.**

DARMHA ID: Application Submit Date: IICP Number:

IMPORTANT NOTICE: This document contains Protected Health Information which is governed by the Health Insurance Portability and Accountability Act (HIPAA) and may only be disseminated to authorized individuals.

APPLICATION TYPE:

☐ Initial ☐ Modification ☐ Renewal

AMHH PROGRAM ELIGIBILITY:

☐ Yes ☐ No

The AMHH Program Eligibility, 405 IAC 5-21.6-4, is denied due to the following reason(s):

☐ Does NOT meet one or more of the eligibility criteria:

- Age 35 or over
- AMHH eligible primary mental health diagnosis
- Medicaid enrolled
- Reside in a home or community-based setting

☐ No recommendation for intensive community-based care (Adult Needs and Strengths Assessment [ANSA] Level of Need is less than 4 and/or ANSA was completed more than 60 days prior to application submission

☐ Does NOT meet one or more of the needs-based criteria:

- Demonstrated need for significant assistance in life domains related to their mental illness
- Demonstrated significant need related to behavioral health
- Demonstrated significant impairment in self-management of mental illness, or demonstrated significant need for assistance with mental health management
- Demonstrated lack of sufficient natural supports to assist with mental illness management
- Not a danger to self or others

You are receiving this letter because of a **DENIAL** for one or more of the services in your proposed IICP under 1915(i) Adult Mental Health Habilitation program. The following service(s) have been **DENIED:**

Denial Date	Procedure Code	AMHH Service Denied	Reason(s) for Denial
MM/DD/YYYY	Service Procedure Code	Service Title	Reasons for denial
MM/DD/YYYY	Service Procedure Code	Service Title	Reasons for denial
(repeated as needed for each requested service that is denied)			

The applicant and Selected Provider will review the Denial Form along with the letter explaining the action. If the service is still requested, the IICP must be reconfigured to provide supporting documentation and re-submitted for review.

Appeal Form for Indiana Medicaid Adult Mental Health Habilitation Services

Indiana Medicaid Adult Mental Health Habilitation Services Denial Notification

Member Information			**Provider Information**
Member Name Member Address City, State, ZIP RID:			Provider Provider Address City, State, ZIP Submitted by: (DMHA SET staff)
Denial Date	**Procedure Code**	**AMHH Service Denied**	**Reason(s) for Denial**
MM/DD/YYYY	Service Procedure Code	Service Title	Reasons for denial
MM/DD/YYYY	Service Procedure Code	Service Title	Reasons for denial
(repeated as needed for each requested service that is denied)			

If you wish to appeal this decision, please read the enclosed Appeal Rights as an Applicant for Adult Mental Health Habilitation Benefits. Sign and date below and return this completed form to begin the appeal process:

Mail to: Indiana Family and Social Services Administration
Office of Hearings and Appeals, MS 04
402 W Washington St, Room
E034 Indianapolis, IN 46204

Fax: 317/232-4412 (Attn: Office of Hearings and Appeals)

I wish to appeal the above decision, for the following reasons:

Signature of Applicant/Guardian: _____ Date : _____
Relationship to Applicant:_____

Appeal Rights as an Applicant for Adult Mental Health Habilitation (AMHH)

If you have questions or disagree with the indicated decision, you should discuss this matter with your selected provider.

Right to Appeal and Have a Fair Hearing:

The Notice of Action provides an explanation of the decision made on your application for services or changes in your services. If you disagree with the decision, you have the right to appeal by submitting a request for a fair hearing. If you are currently receiving AMHH Services and your renewal application has been denied, your AMHH Services will continue if your appeal is received within the required time frame described below under "How to Request an Appeal" unless you request to end services.

Can I continue to get benefits when my appeal is pending?

New services cannot be started but you may keep your current benefits until an Administrative Law Judge (ALJ) issues a decision after an evidentiary hearing. In order to maintain your current benefits, you must file your appeal:

a) Within 10 calendar days of the date of the Notice ; or
b) Before the date that the agency's decision goes into effect, whichever is later.

Any benefits you receive while your appeal is being decided may have to be paid back if the ALJ determines that the original decision is correct. However, you will only be responsible for paying back benefits provided to you on appeal after the authorization period.

How to Request an Appeal:

1) If you wish to appeal this decision, the appeal request must be received by close of business not later than:
   a) 33 calendar days following the effective date of the action being appealed; or
   b) 33 calendar days from the date of the notice of agency action, whichever is later.

2) To file an appeal, please sign, date and return the enclosed *Appeal Form for Indiana Medicaid Adult Mental Health Habilitation Services:*

Mail to: Indiana Family and Social Services Administration
Office of Hearings and Appeals, MS 04
402 W Washington St, Room E034
Indianapolis, IN 46204
Fax: 317/232-4412 (Attn: Office of Hearings and Appeals)

3) If you send a letter rather than this Notice of Action, be sure that the letter contains your full name, address and telephone number where you can be reached. Please attach a copy of this decision to the letter and state the name of the action you are appealing. If you are unable to sign, date, and return this form to the above mentioned address, you may have someone assist you in requesting the appeal. A telephone request for an appeal cannot be accepted.

4) You will be notified in writing by the Indiana Family and Social Services Administration, Office of Hearings and Appeals of the date, time and location for the hearing. Prior to, or at the hearing, you have the right to examine the entire contents of your case record maintained by the Selected Provider.

5) You may represent yourself at the hearing or you may authorize a person to represent you, such as an attorney, relative, or other spokesperson. At the hearing you will have full opportunity to:

   a) Call witnesses;
   b) Establish all pertinent facts and circumstances;
   c) Advance any arguments without interference and question; or
   d) Refute any testimony or evidence presented.

APPENDIX E: EXAMPLE CRISIS PLAN FORMAT

Example Crisis Plan
Diagnosis and current medications:
Brief history of crisis encounters and outcomes:
Known triggers:
Anticipated potential crisis situations:
Action Steps and Person(s) Responsible:

APPENDIX F: CMHC PROVIDER AGENCY APPLICATION AND ATTESTATION TO PROVIDE AMHH

CMHC PROVIDER APPLICATION AND ATTESTATION TO PROVIDE ADULT MENTAL HEALTH HABILITATION SERVICES

I, _____, CEO of _____ CMHC, attest to the following:

_____CMHC is:

- a FSSA/DMHA-certified Community Mental Health Center (CMHC) in good standing
- an enrolled Medicaid provider
- willing and able to provide AMHH services as described in the CMS approved 1915(i) State Plan Amendment (SPA) (TN12-003), AMHH rule (405 IAC 5-21.6) . and the AMHH Provider Manual (see attachment A) to meet the identified habilitation needs of each eligible recipient
- committed to ensuring that recipients have access to the services and supports needed to meet his/her individual needs.

The signature below attests that _____ CMHC requests to become a FSSA/DMHA approved AMHH service provider in the state of Indiana. The above requirements and referenced documents have been read, are understood, and will be implemented per FSSA program standards.

_____

Date:_____

Community Mental Health Center CEO

APPENDIX G: AMHH APPLICATION STATUS CODES

This table provides the status codes that are viewable in the *Application Status* field of the AMHH application in DARMHA. The status code will be updated whenever a new action is taken on an AMHH application. Providers can use this code to track where an application is in the process.

Status Code	Description
Discarded	The application was discarded by the provider or was in draft mode for more than 60 days and was discarded by the FSSA/DMHA State Evaluation Team. Applications discarded for either reason have not been submitted for review by the FSSA/DMHA State Evaluation Team.
Draft	A draft was saved by the provider. The application has not yet been submitted for review by the FSSA/DMHA State Evaluation Team.
Submitted	The application was submitted by the provider and is undergoing FSSA/DMHA State Evaluation Team review.
DMHA Pending	The application was pended by FSSA/DMHA State Evaluation Team for review and potential updates to be made by the provider (i.e., the supporting documentation is inconsistent or insufficient for the FSSA/DMHA State Evaluation Team to make a program and/or services eligibility determination). If not resubmitted within 7 calendar days will be denied based on original submission.
DMHA Approved	The applicant has been approved for AMHH eligibility by the FSSA/DMHA State Evaluation Team and all requested services were approved. The application will be forwarded to HP for service package assignment.
DMHA Approved with Partial Services	The applicant has been approved for AMHH eligibility by the FSSA/DMHA State Evaluation Team, but one or more of the requested services were not approved. The application and approved requested services will be forwarded to HP for service package assignment.
DMHA Denied	The application has been denied by the FSSA/DMHA State Evaluation Team. Therefore, the individual is not AMHH eligible.
HP Data Sent	The applicant was approved by the FSSA/DMHA State Evaluation Team and the information has been sent to HP for AMHH service package assignment.
HP Error	An error would occur if the information sent from DARMHA doesn't match what HP has in their system for that RID (last name, DOB, gender, etc.), or if the format of the file was incorrect.
HP Processed	An AMHH service package assignment has been generated by HP. AMHH start and end date and assigned units are viewable in Web interChange.